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UNNECESSARY SURGERY: DOUBLE JEOPARDY FOR OLDER AMERICANS

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING UNITED STATES SENATE

NINETY-NINTH CONGRESS

FIRST SESSION

WASHINGTON, DC

MARCH 14, 1985

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UNNECESSARY SURGERY: DOUBLE JEOPARDY FOR OLDER AMERICANS

THURSDAY, MARCH 14, 1985

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The committee met, pursuant to notice, at 9:30 a.m., in room SD-562, Dirksen Senate Office Building, Hon. John Heinz (chairman) presiding.

Present: Senators Heinz, Grassley, Denton, Glenn, Chiles, Burdick, and Dodd.

Also present: Stephen R. McConnell, staff director; Robin L. Kropf, chief clerk; James F. Michie, chief investigator; David Schulke, investigator; Isabelle Claxton, communications director; Jane Jeter, minority professional staff member; Leslie Malone and Lucy Savidge, staff assistants; and Gene Cummings, printing assistant.

OPENING STATEMENT BY SENATOR JOHN HEINZ

Chairman HEINZ. The hearing will come to order.

Good morning, ladies and gentlemen. We are here today to focus on a problem of critical importance for all older Americans: The double-edged threat of unnecessary surgery.

Americans of all ages are being wheeled into operating rooms at greater annual rates than any other place in the world. During the past decade, the over-all surgery rate in the United States increased four times faster than the growth in population. We spent over $20 billion on Medicare paid-for surgery alone in 1984; and, of course, billions upon billions of additional dollars were billed to private patients and insurers.

Americans over the age of 65 are statistically prime candidates for the surgical table. They are also the most vulnerable of our citizens to the physical risks associated with an operation. Senior citizens undergo 80 percent more surgeries each year than the rest of the population—nearly twice as much. Among the elderly, each decade of age brings a doubling in the death rate associated with surgery.

Added to this jeopardy to life is the jeopardy to large out-of-pocket expenses associated with surgery; older persons on a modest fixed-income can least afford that.

Already, a Medicare beneficiary pays a minimum of $400 for each hospitalization; this payment is expected to rise 56 percent, to $624 in 1990, and, when coupled with the copayment on the physician's bill and the rising costs and limited coverage for post-operative community care, the financial risks of surgery are painfully clear.

Yet, whether it is the result of inexperience or ignorance or greed on the part of some doctors, millions of older Americans each year face the double jeopardy of unnecessary surgery. Proof of this national disgrace is all too evident.

While we are going to hear some additional proof from our witnesses, let me just cite the following examples:

In 1982, a Special Committee on Aging Investigation, of which I was privileged to chair, revealed that 30 to 50 percent of all cardiac pacemaker implants were unnecessary. Close to $1 billion was spent by Medicare therefore needlessly.

A Federal study of coronary artery bypass surgery found that this very expensive and commonly performed elective procedure has "no over-all benefit" compared to less risky treatments. Yet, bypass surgery on older men increased by almost 1,000 percent in the 1970's.

There is a huge disparity in the number of operations performed on a region-by-region basis under Medicare's DRG's—diagnostic related groups. This suggests that doctors engage in "surgical fads," recommending the "popular" surgery over what might be a less risky, less costly alternative.

Our first panel of witnesses today are here, and we have three older Americans who escaped the scalpel for less traumatic cures, simply by exercising good consumer judgment. Each of these three sought a second opinion, once surgery was recommended.

The value of a second professional opinion to confirm the need for elective or nonemergency surgery is not a new concept. Ten years ago, a congressional investigation into the problem of unnecessary surgery, under Medicare and Medicaid, concluded that approximately 2 million procedures—that is 2 million procedures—performed that year, at a cost of over $4 billion, were unnecessary. The final recommendation of the investigation was a mandatory second surgical opinion for elective surgery under both these Federal health programs. A report to be released today by the Special Committee on Aging holds the promise of a dramatic saving for Medicare through second opinion. Committee statistics show that reducing unnecessary surgery in just nine procedures will save Medicare up to $1 billion a year.

Use of the mandatory second opinion in the private sector has grown dramatically over the past several years, with startling results. Rates for certain targeted surgical procedures fell as much as 60 percent. Net savings for the insurers range up to $8 saved for every $1 spent in implementation.

Despite the early attention by Congress to the life- and cash-saving benefits of a second opinion, and the growing volume of evidence in its value in the private sector, the administration and the Health and Human Services Department have spun its wheels on this issue. A large part of our focus will be on getting these wheels in gear.

We will hear from several expert witnesses on the benefits of a second opinion requirement for a small number of high-volume, high-cost elective surgical procedures for both Medicare and Medicaid.

One other reason that we need to focus very hard on over-utilization, which is broadly what we are talking about, is that we have been confronted each year for the last 4 years, and are likely to be confronted in many, many years to come, with many provisions to save costs to reduce the expected deficits in the Medicare Program. More often than not, these proposals are aimed at getting Medicare beneficiaries to pay more, whether it is through higher premiums, higher copays or higher deductibles.

The new DRG, diagnostic related group, methodology has nothing to do with stamping out, limiting, or holding down the costs associated with over-utilization. They are aimed at saving money, but, indeed, DRG's, where hospitals are reimbursed on a case management per-case basis, may even encourage over-utilization as hospitals try to make up on volume what they cannot any longer make up on simply billing additional costs per procedure.

As a result, it is tremendously important that we focus public attention and future public debate, whether it is in the administration, in the Congress, or in the media, on the fact that before anybody starts talking about raising costs to Medicare beneficiaries, we look at the Medicare system, at the costs incurred unnecessarily in it, whether it is by over-utilization on pacemakers or whether it is through unnecessary surgery, which might, in many cases, be avoided on elective surgery through a mandatory second opinion.

Having said that, I just want to add that we do have an imminent—4 to 6 years out—financial crisis in the Medicare Program. It is of deep concern to us all, and we must leave no option unturned in our battle to break what is now Medicare's plunge into the red. Eliminating the cost of unnecessary surgery with the mandatory second opinion is an option whose time has truly come.

I would like at this time to welcome our panel of witnesses. It is a most distinguished, unusual and colorful panel.

Mr. Larry Penberthy is a businessman from Seattle, WA. He will share with us his story of repeated near-misses with unnecessary cardiac bypass surgery.

Mrs. Mary Armstrong is a retired schoolteacher from Evergreen, IL. I understand she is going to tell us about how a second opinion saved her from bilateral bypass operations in both legs.

Our third witness, who has had experience with a second surgical opinion, is Mr. Wallace Law of Pinehurst, NC, a retired Illinois Bell Telephone System Engineer who is going to tell us about how he avoided back surgery, which might have left him paralyzed.

We have two medical researchers also on our panel, Dr. Thomas Graboys, from Lown Cardiovascular Laboratory at Harvard University School of Public Health in Boston; and Dr. Eugene McCarthy, who is director of the Health Benefits Research Center at New York Hospital, Cornell University, and has been administrating and studying second opinion programs for the past 14 years.

Mrs. Armstrong and gentlemen, we appreciate each of you taking the time to be here today. I believe all of you have submitted prepared statements, and they will all, in their entirety, be made a part of the hearing record.

In order to save time, the Senate does go back in at noon, we have two more panels after you, let me ask you to be as brief as possible. Where I need to get additional information, I will question you; but, before we begin I just think it is important to point out to you, Mrs. Armstrong, Mr. Penberthy, and Mr. Law, are our witnesses who did seek second opinions. In a sense, you are exceptional, in that even in organized and promoted voluntary second opinion programs, there is only 2 percent or less participation. You are, therefore, really quite exceptional; and, as a result, the vast majority of individuals like yourselves do not, as a rule, obtain a second opinion.

Mr. Penberthy, may we begin with you? Welcome to the committee.

STATEMENT OF H. LARRY PENBERTHY, SEATTLE, WA

Mr. **Penberthy**. Thank you, Senator Heinz; and thank you for inviting me.

I have a special situation here, where I got not just one second opinion, I had five of them, and then actually the only one that counted was the sixth one, which was from one of my mountain-climbing friends.

I will give you the punch-line of what I am going to say in the very first sentence: The cardiologist who practically ordered me to have a heart bypass in 1977 has just purchased a million-dollar house.

Chairman **Heinz**. Maybe we should just adjourn the hearing and call it a day. [Laughter.]

Mr. **Penberthy**. That may say it all, Senator.

Now, I have been active all my life in mountain climbing. I come from Seattle where we have many mountains, mountain climbing has been my hobby. I noticed that I had been slowing up in mountain climbing, but I never have been very fast, and so this is not something that came on quickly. I volunteered for a community study on treadmill performance in men over 50, and I ran 12 minutes, which was not bad, but there was a change in the electrocardiogram which led to a recommendation to see a cardiologist. That led to a heart-catherization study almost automatically, and with the same degree of automation it led to the cardiologist practically ordering me to have a heart bypass within 10 days. He would not even wait 2 to 3 months. He said it was very urgent and all that.

But, one of my climbing friends, Allan Pribble, who is a cardiologist working for the VA—he could not serve me directly as a cardiologist—but, he said, hey, wait a minute, take it easy, I know how you climb and I know it is a little slower than other people, but you are doing a tremendous performance—I had just climbed Mount Rainier, 14,000 feet—and so I did not exactly feel ill or ailing; got along just fine.

So I slowed up a bit. I talked with Pribble's friend, Dr. Tom Preston, who has published frequently on this subject, to say: Hey, wait a minute, too many bypasses going on.

So I was supplied by them, and by my own searching with a good deal of information, articles written by others who had advised caution; and that led me, then, to defy the original doctor. But, remember now, there is a real problem in defying the doctor. The doctor has three levels of influence on you: First of all, he is working in an occult art, and the——

Senator HEINZ. Magic.

Mr. PENBERTHY [continuing]. The witch doctor of old had a great deal of influence over his patients, because the patient did not know what the witch doctor was doing. Now, it did not make any difference to the witch doctor himself, he did not know what he was doing, but that is sort of a carryover. The doctor is an authority figure, and he does things that the average person does not understand. He has a vocabulary that is not familiar at all.

Now, here is another aspect that came up in my case: The doctor used the influence of drugs on me. He may not have done it so consciously as I am saying it. But he put me immediately on 80 milligrams of propranol (Inderal). Well, for a person who has not been taking that drug, that is about a one-third knockout. I had no energy, I was lethargic, I just could not push, and this was not right at all. I stayed on that prescription for 2 days. When I realized that in that condition I might go for the bypass in order to get rid of the drug problem. I stopped taking the propranol and snapped back to my normal energy.

Third, the doctor can put into a person the fear of death. It was an area I did not understand. I did not have the information. And so, therefore, I was seeking some help that would give me the rational view. I am a physicist-engineer, and I am accustomed to studying things. And in this case I did not have the information, and that is why I kept on going and was looking. Well, it finally turned out that I became my own cardiologist. That was the basis on which I am making my decisions now.

I want to just reinforce one phrase that you used. You said "surgical fad". That is right. A second opinion is not enough, because the second opinion may be a man who is of the same fad, or he may even be a working partner. I had that happen. And working partners often have the same philosophy and have the same things to gain by the same recommendations.

Now, one thing that they did miss in my case that should be in: they were not astute enough to realize that I had had a long history of active, sustained exercise. Mountain climbing is slow. You are not like a sprint runner, but you sustain for hours at a time. And that has the physiologic effect of developing collateral arteries. And in my case it was clearly visible on the cini-films that I had two very well-developed collateral arteries, and I had been using those for years—a couple of decades probably—which permitted me to operate at, say, around 60 percent of performance and which I can continue to do so, because they were perfectly clear. They bring blood around the blocked arteries and feed into the capillaries from below.

Five of the six doctors missed this important factor in my favor in opposition to a heart bypass operation. Thank you.

Chairman HEINZ. Mr. Penberthy, I will have a few questions for you later, so do not go mountain climbing just yet. [Laughter.]

Mrs. Armstrong, welcome.

STATEMENT OF MARY MARGARET ARMSTRONG, EVERGREEN PARK, IL

Mrs. **Armstrong**. Thank you for having me here, Senator Heinz, and getting me out of Chicago where it was snowing. Illinois has no mountains, so my husband and I have been square dancing for many, many years.

And, in recent years, I found that I was having more pains in both legs, starting at the ankles and going on up behind the knees. I attributed it to arthritis. So, eventually, I went to an arthritis specialist. He examined me and said no, I had a circulation problem. He sent me to a circulatory specialist who, just like the other gentleman's experience, was ready to put me in for bypass surgery in 2 weeks. He wanted me to come for a treadmill test, and maybe at least stay for the bypass surgery in both legs, between the knee and the thigh. So I decided on a second opinion; went to another specialist in circulation problems. He said bypass surgery in that area is not too successful—that if it were in the stomach area it might be better—but he did not recommend it there. And he said my problems were not severe enough to warrant such a radical approach now. And he recommended that I walk. A schoolteacher is a pretty sedentary person—and he recommended that I try to lose some weight. So I have attempted to do both, and maybe do more of it as summer comes on.

Another thing that deterred me from the surgery was the fact that I do not take well to anesthetics. I had had major surgery in 1976 and I stayed out all day long and did not come to from the surgery until late that night, to the extent that the doctor kept coming back all day wondering why I was still in dreamland. So I did not welcome having to go through any more surgery. He suggested at that time that if I ever did need surgery, that the anesthetist look up the 1976 records and find out what he might have to do with me currently. So that was my experience with the second opinion.

Chairman **Heinz**. Thank you very much.

Mr. Law.

STATEMENT OF WALLACE V. LAW, PINEHURST, NC

Mr. **Law**. My problem started with golf. At this late age, I decided to buy some new clubs to see if I could beat my wife and I went at it a little too hard, I am afraid. Last September I ended up with some severe pains in the back and the right leg, sciatic nerve.

My internist referred me to an orthopedic man, principally with the idea that I might undergo enzyme injection into the spinal area to eliminate my problem. The orthopedic surgeon felt that that was not safe and suggested that I have a laminectomy.

Well, I had had one in 1966 and had a rather difficult time with it. And this doctor said that I had only a 50-50 chance of success with this surgery, but what scared me more was the fact that there was a 50-50 chance that I might end up paralyzed.

About that time the Illinois Bell Co. had just published a treatise on where we could get some counseling relative to second opinions for elective surgery. After discussing the problem with Healthwise Counseling Service, which is administered by Parkside Medical

Services Corp., an affiliate of Lutheran General Hospital, in Park Ridge, IL—use of the service is available to employees and retirees of Illinois Bell on a completely voluntary basis, and is fully paid for by Illinois Bell—I then went to see another orthopedic surgeon, who felt that I should not have surgery and felt there was a chance to come out of this without surgery.

He ordered cortisone injections in the spine. That brought me some relief. Then he brought in his compatriot, a neurosurgeon, who confirmed the opinion that there was another way out of it besides surgery for me. I had another cortisone injection in a month, from which I received substantial relief. One month later, I was given some oral cortisone. I am able to move around now without wanting to blow my head off; but I am going to a chiropractor right now who has brought me some additional minor relief in just the last 2 weeks.

So, I am still not all the way cured; I do not know if I will ever play golf again, and the doctors do not know.

Chairman HEINZ. But you are feeling pretty well?

Mr. LAW. I am feeling better, when I cannot sit down, I have to lie down.

Chairman HEINZ. But your handicap is still too high.

Mr. LAW. I am afraid it is, yes.

Chairman HEINZ. Very well. Mr. Law, thank you.

We will have some questions for all of you.

Let me now turn to our two medical researchers of the panel, Dr. Graboys and Dr. McCarthy.

Dr. Graboys, you may proceed.

STATEMENT OF DR. THOMAS B. GRABOYS, DIRECTOR, CLINICAL SERVICES, HARVARD UNIVERSITY MEDICAL SCHOOL, BOSTON, MA

Dr. GRABOYS. Good morning. I feel privileged to appear before this committee.

Our interest in the area of second opinions began about 10 years ago. At that time, we were seeing a good number of individuals who were coming to us for a second opinion as to the need for heart catheterization, as well as for cardiac surgery.

We began to collect data between 1975 and 1981 on a group of patients that we followed for 5 years. That period of time paralleled the increasing number of people who were undergoing coronary surgery. It also paralleled the increased awareness by the public of the whole issue of coronary artery disease, the narrowing of the blood vessels that go into the heart, and the reality that sudden cardiac death was and continues to be the number one cause of death in this country.

Coronary surgery appeared as an attractive, almost seductive, beacon on the horizon. It made absolute sense. Many people viewed it as plumbing, and that is part of the issue. If there is a narrowing of a vessel and you take another vessel from somewhere else in the body and you bypass it, it appears that the problem is solved but, clearly, this is a far more complex issue.

The reality is that none of us can say with absolute certainty what causes angina or how coronary surgery prevents or ameliorates this particular symptom. More germane, however, is the issue of survival and the number of people who are subjected to this operation, because of the fear of sudden death and the hope that it will prevent heart attack and prolong life.

The third element contributing to the increased number of coronary surgery was the enormous number of cardiologists and cardiovascular surgeons produced in this country over the past 10 years.

In 1981, we published, in the New England Journal of Medicine, a study that was carried out on 142 patients who had come to us for a second opinion as to the need for heart catheterization or cardiac surgery. Those folks were deemed exceedingly high risk, thus warranting this heart catheterization or presumed surgery.

We found, in fact, that patients who had stable symptoms, irregardless of these test findings, did very well in a 5-year followup. In fact, we had less than 1 percent coronary mortality.

Now, the study, once it was published, provoked much disquiet.

Senator **Chiles**. These people had surgery?

Dr. **Graboys**. No.

Senator **Chiles**. They did not.

Dr. **Graboys**. No. These are people who came to us for an opinion as to, should they have a heart catheterization. Some of them came to us because they had had a heart catheterization and it was suggested that they have surgery. We basically said, "Look, we do not think you have such a terrible problem; let us follow you along", and we did. In fact, they did very well.

Following the paper that was published in 1981, we began to see a large number of individuals who came to us for the specific issue of the need for heart surgery. All of these people had had a heart catheterization. Most of them had dates for cardiac surgery. And so the specific issue was a second opinion as to the need for cardiac surgery.

The demographics of the patients were that most were men, 90 out of the 100; the average age was about 60, with a range of 40 to 79. And I think I might qualify that by saying all of these individuals were quite motivated. Second opinions are appropriate for this kind of population, but not for individuals who are hospitalized for having significant symptoms and are deemed medically unstable. The population I will describe is a medically stable population.

Most of the individuals who came, the justification for the surgery was based on angina pectoris or heart pain—40 percent. Then 25 percent, in the brown at the bottom of the chart, had had pain and a previous heart attack. Then there was about 11 percent who had had an exercise test which was deemed significantly positive and, in addition, had pain. But 10 percent came to us with exercise test findings alone, and this is not an unusual scenario.

Chairman **Heinz**. Let me just ask you, Doctor, of the pain alone, that was a chest pain of some kind?

Dr. **Graboys**. No; again, all of these patients had heart catheterization, which means that they had suitable anatomy. They had narrowing of more than two vessels. So, if you want to say justification, the justification in fact was based on the fact that they had heart catheterization, which showed me they had coronary artery disease.

The question is: How did they get to heart catheterization in the first place? So the indication for the heart catheterization, to define the problem, we examined persisting symptoms. Most of them had angina, 65 percent; 40 percent angina alone, which is chest pain, and an additional 55 percent had had a previous heart attack, plus were experiencing chest discomfort.

Senator **Denton**. Excuse me, Dr. Graboys. I understood his question, but I really did not understand your answer. First-opinion physician, coronary artery bypass surgery; the justifications for those include a 40 percent figure for those whose recommendations for catheterization were based upon pain that these people had in their chest, or not? And that is all, pain.

Dr. **Graboys**. Yes; chest pain alone.

Senator **Denton**. That is absolutely incredible to me. I just had, not the bypass surgery, but the angiogram, and the catheterization takes place in that, as you know. There was no ripoff of me in that, in that my brother is a doctor, a heart doctor. I am a rear admiral retired from the Navy and I am a Senator; so they were going to be pretty careful about how they dealt with me, because I went to Bethesda Naval Hospital. And it was very, very carefully looked into.

In fact, the doctor in Florida, from whom I got the original suggestion that maybe I should get it, told me that about half the doctors would say you should not have to have this, anyway. Mine was based on pain, it was based on a treadmill test, with the variation in the way my heartbeat went or something; I do this every year as an ex-POW. Then on a thallium and another test which were inconclusive.

Yet, after all that deliberation, they still were not sure and they let me make the choice, because I play tennis and golf intensely, and I work intensely; they said, So, maybe you want to find out that you have to alter your lifestyle, get a little medicine or something.

So, after all this deliberation, and leaving it up to me, they let me take the angiogram, which has a slight risk itself. It is indescribably amazing to me that 40 percent of the people who got first-opinion bypass surgery were based on just the pain that they felt in the chest, because I had that, too.

Dr. **Graboys**. Senator, to be absolutely fair, the people who we saw were experiencing chest discomfort. They had gone to their internist, let us say, and they had been put on medication, and then perhaps they were continuing to experience chest discomfort, and on that basis they were sent to a cardiologist who said, "OK, you are having symptoms, you are on medication, the symptoms are chest discomfort, which I believe is coming from your heart; we should do a catheterization." Then they did the catheterization, found that they had narrowing of several vessels and said, "You need an operation."

Senator **Denton**. So, really, what you are saying is that 40 percent from pain alone got—or some percentage—got catheterization; and of those who indicated heart disease, of those tests, they got surgery.

Dr. **Graboys**. Oh, yes. But all of these people had narrowing of blood vessels. They all had heart catheterization. And this simply indicates how they, in fact, got into the system, how they ended up having a heart catheterization, on the basis of which it was suggested they have coronary surgery.

Chairman HEINZ. Dr. Graboys, just to clarify the point for everyone, the question was not, therefore, whether these people had any coronary artery disease; they all had it?

Dr. GRABOYS. Yes, sir.

Chairman HEINZ. The question, therefore, was: given the nature of that disease, whether coronary bypass surgery would do them any good——

Dr. GRABOYS. That is right.

Chairman HEINZ [continuing]. Would increase or decrease their health risks, would result in benefits greater than the cost to them—and I am not talking financial cost, I am talking all other kinds of cost. And that, what you are saying, as I understand your chart, is that simply to have a catheterization that proves that you have some coronary artery disease and have the symptom of pain is not necessarily a very good reason to have coronary bypass surgery.

Dr. GRABOYS. Exactly.

Chairman HEINZ. This is probably a dangerous analogy, but it is like someone saying: You have a headache and you have a sore throat, therefore you ought to take a strong antibiotic; without knowing whether or not you really need that strong antibiotic, which may ultimately be a bad thing for you to have. Is that a good or a bad analogy?

Dr. GRABOYS. It is a fair analogy.

Chairman HEINZ. Fair analogy. [Laughter.]

Now, we all know that doctors in this country overprescribe antibiotics to a dangerous degree.

Dr. GRABOYS. We do not do the catheterization to see what is there, unless there is a significant question.

Chairman HEINZ. Maybe to illustrate the point, let us take Mr. Penberthy's case, which is very interesting. Nobody out there can probably see this, but Mr. Penberthy is an engineer; and he drew a picture in this letter that he wrote to his doctor of the coronary arteries in his heart. As I understand, what he drew—he demonstrated that there was a blockage in a larger artery which coincided with the point at which a smaller artery was connected with the big artery. The doctor was prescribing the Grundzig treatment which, I gather, is something like a Roto-Rooter. [Laughter.]

He pointed out, as somebody who understands the laws of physics, that if they made the particular procedure the way they had intended to do so, that it would probably block off the subsidiary artery, causing him a heart attack.

Mr. Penberthy, is that essentially an accurate description of what you pointed out to your doctor?

Mr. PENBERTHY. Yes, it is.

Chairman HEINZ. Would you tell us what your doctor said after you pointed this out to him?

Mr. PENBERTHY. That cardiologist was the third one I went to. He is the one who said I would be an excellent candidate for angioplasty. He had just heard a lecture on it. So I wrote this and showed him that maybe he did not have it quite straight. He had never bothered to look at the cinifilms.

Now, this I fault him for, he should have looked at all available evidence. He said I was an ideal candidate. I wrote back this letter of explanation of why I thought it was wrong, and he went back to the guru, the source, and the guru agreed with me that, yes, it was inadvisable.

Chairman **Heinz**. So the doctor you wrote said that he was wrong and you were right? After checking with——

Mr. **Penberthy**. Yes, he backed off; in the letter he——

Chairman **Heinz**. I guess the moral to this discussion is just because you have got coronary artery disease and just because you have got pain, as Senator Denton suggests, it is really not a very good reason to rush onto the operating table.

Senator **Denton**. If you will yield, Mr. Chairman, I think I now understand. To show the difference between what you are reporting and what I was told, the doctor who did not know me, the ones in Florida and my Navy doctor in Pensacola, know me and they knew I probably did not have heart disease, but they decided to go ahead and give me the choice of taking this anyway. The doctor here in Bethesda, not knowing me at all, just said, "You know, you are 61 years old, you are an American male, I will bet that there is a 60 percent chance that you have some kind of heart disease," which was different from what they told me down there, because they knew that I was fairly active, I could beat all my boys playing tennis, and all that sort of thing.

Chairman **Heinz**. I will vouch for Senator Denton's ability on the tennis courts, too.

Senator **Denton**. But, anyway, the fellow up here said, "There is a 60 percent chance you have heart disease, just on those statistics alone; but," he said, "even if you do have heart disease, I will predict there is not 1 percent chance that you are going to have to have bypass surgery or any other surgical procedure." He said, "You will probably have to have, perhaps, some medicine or a change in your diet, and that is all."

Now, that was his pessimistic appraisal which contrasts amazingly with what you have been saying was the analysis which led to that. Now do I have it kind of straight?

Dr. **Graboys**. Yes.

Senator **Denton**. OK.

Chairman **Heinz**. Dr. Graboys, are you going to explain the second chart?

Dr. **Graboys**. Yes; the table on the left discloses the results of 100 patients who then came up for a second opinion. Of those 100 patients who came to us, we recommended bypass on 15; and 85 we felt could continue on medical therapy.

Now, of the 85 who we suggested that they have continued medical therapy, 9 crossed over. In other words, they decided that they wanted to have bypass. They came for a second opinion, they heard our opinion, and they went ahead and had the operation.

We followed then 75 for—the average now is about a year and a half, 18 months; the range is 6 to 38 months. And, basically, as you can see—it does not show it there—but, of the 75 who we continued on medical therapy, we have had one death. The bottom line is that this was a group of stable patients who, despite having significant narrowing of two and three vessels, were really medically stable. We made changes in their medical program. We spent a good bit of time with them, trying to assess their motivation for continued medical therapy, trying to kind of demystify the whole issue.

And that, I think, warrants just a word, because if someone says to you, "Listen, my friend, you have got 95 percent narrowing of a vessel, it provokes much disquiet on the patients part." That gets back to this image that we have of it being simply plumbing.

Psychologically, how does one carry on knowing that you have narrowing of three vessels going into your heart of that degree, expecting any minute they might close off. But the fact is that data from the CASS study and from our own work has demonstrated that this is not an issue; the issue is the integrity of the heart muscle, and these people all had good heart muscles.

However, in our decision to recommend medical therapy versus surgery, much of it was dependant upon the psychologic status of the patient and the patient's spouse. If we felt that the home environment was a lot of tension and if the wife was extremely anxious that every breath might be her husband's last, and that we did not think we could decompress this family then we would recommend surgery.

Chairman HEINZ. Dr. Graboys, let me interrupt you. Senator Chiles, who was the chairman of this committee before I was fortunate enough to become chairman, is here and I know he has another appointment. Let me yield to you, because I know you were up late last night with a sick patient called the Federal budget.

Senator CHILES. We are still working on him now. I am delighted to be here to decompress this issue. You have made me feel a little better and my pain is not as great as it was when I came in. [Laughter.]

Chairman HEINZ. I noticed that the operation last night was a success, but we are still not sure about the patient.

Senator CHILES. That is right. Well, I am delighted to see you holding these hearings. I think it is an area of great interest and one in which we fully need to explore, and I wish I could stay a little longer to hear more of this testimony. I look forward to reading the record on it. Thank you.

Chairman HEINZ. Senator Chiles, thank you very much for being here.

Dr. Graboys, do you want to explain what happened to the 15 who chose surgery?

Dr. GRABOYS. Well, actually it was 24 who ultimately had surgery; 15 plus 9 who crossed over; and there were 2 deaths in that group, one in an automobile accident. But the mortality in either group was very low. That is the key issue.

Chairman HEINZ. That is the message there.

Dr. GRABOYS. That is the message. And when you look at the cost, the implications of the cost for just these patients, I estimated, based on a conservative figure of $20,000 per bypass operation, of the 75 patients that we continue to manage medically, the direct cost was a savings of $1.5 million.

Now, if we include the cost of our medical treatment and if we include the fact that a certain number of those patients had a second hospitalization, the savings still is about $1.4 million, and you can extrapolate this significantly, I think, when you look at the large numbers of people involved.

Chairman HEINZ. Some people have estimated that 30, to 40, to 50 thousand bypass operations that are performed each year are totally unnecessary. Anybody who can multiply that out comes up with a very large number.

Thank you, Dr. Graboys.

[The charts referred to follow:]

CHART 1

JUSTIFICATION(S) OF FIRST OPINION PHYSICIAN FOR CORONARY ARTERY BYPASS SURGERY

(100 PATIENTS)

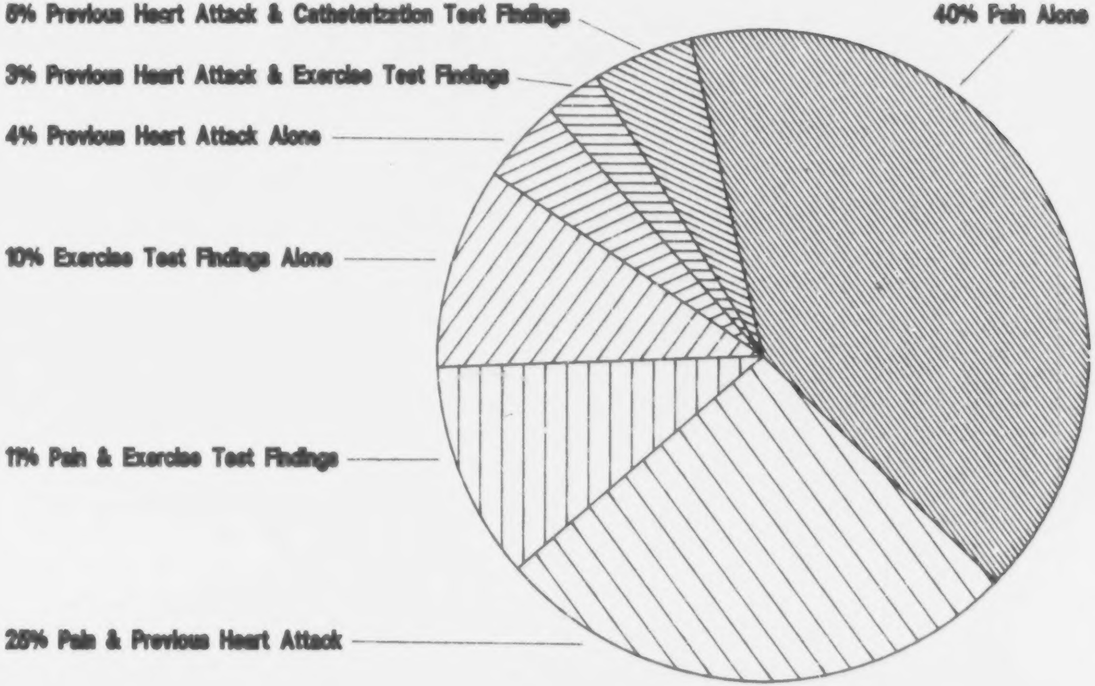
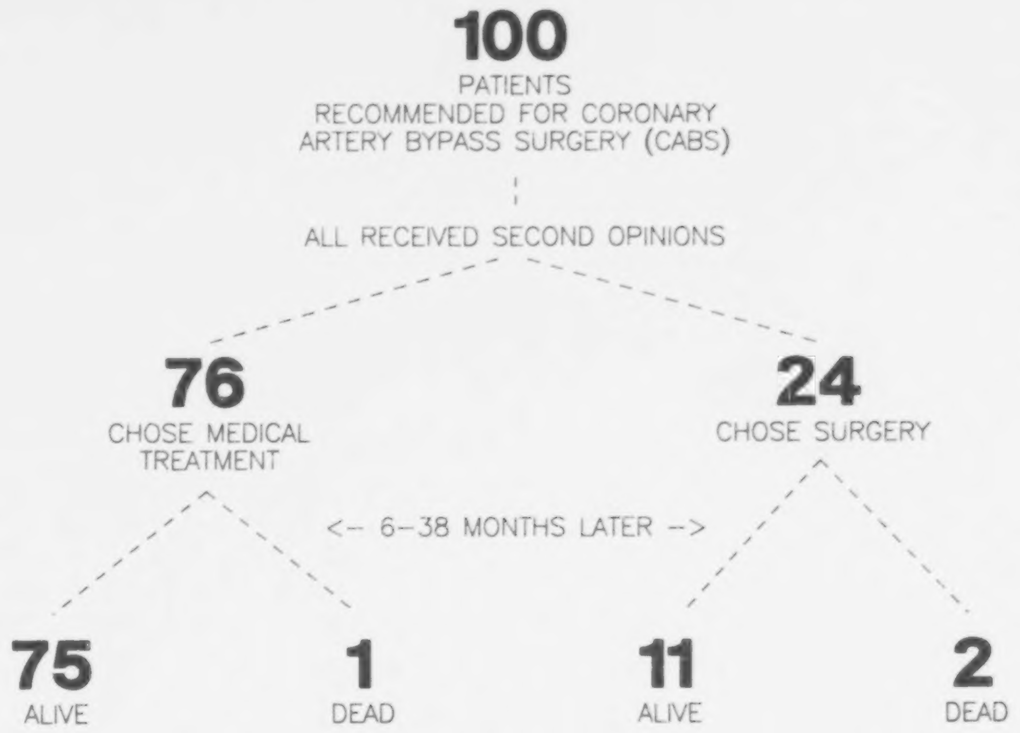


CHART 2

IMPACT OF SECOND OPINIONS ON REDUCING CORONARY BYPASS SURGERY (CABS)


100
PATIENTS
RECOMMENDED FOR CORONARY ARTERY BYPASS SURGERY (CABS)
ALL RECEIVED SECOND OPINIONS
76
CHOSE MEDICAL TREATMENT
24
CHOSE SURGERY
<-- 6-38 MONTHS LATER -->
75
ALIVE
1
DEAD
11
ALIVE
2
DEAD

(RESULTS ON 11 CASES NOT YET AVAILABLE)

Dr. McCarthy.

STATEMENT OF DR. EUGENE G. McCARTHY, DIRECTOR, HEALTH BENEFITS RESEARCH CENTER, N.Y. HOSPITAL/CORNELL UNIVERSITY, NEW YORK, NY

Dr. McCarthy. Thank you, Senator.

I am going to focus a little bit on the broad picture and am not going to be specific to any one particular diagnosis. I wish to thank the chairman and the committee for inviting me.

In 1970, I, as principal investigator at Cornell, NY, Medical Center, developed what was then the first operational Second Opinion Program in the United States. Now, that program was in and around the Greater New York area, including New Jersey and Connecticut. The motivation of those programs was to benefit the consumer patient by improving the quality of his or her decision in undergoing a major elective surgery.

As I indicated in other congressional committees in the past, the Second Opinion Program addresses the reality of unnecessary surgery that exists in the country at the present time. Access to another opinion from a board-certified specialist of the patient's choice arms the individual with a more informed decision regarding the advisability of elective surgery.

Second Opinion Programs endeavor to make the patient aware of the choice available to him in the treatment of his particular condition; for example, an alternative to surgery, in essence; medical treatment or, in some cases, no treatment at all. The second opinion can also serve to reassure the patient, when the consulting physician agrees, that the proposed surgery is the clinical course of action.

Improvement in the quality of health care is obviously the primary goal of this program in an environment of excessive care that exists now and, unfortunately, will persist in the foreseeable future.

There is also a financial rationale for Second Opinion Programs that is especially important in this time of health care cost consciousness. One of the goals of the Second Opinion Program is to prospectively evaluate the need for a procedure and to decrease inappropriate surgery, thus reducing the cost of health care. The number of operations performed in short-stay hospitals has increased at a rate many times faster than the population growth rate. The rates of surgery per thousand population increased 93 percent in the last 10 years, from 1971 to 1982. We can see this in table 1.

[Table referred to follows:]

TABLE 1.—NUMBER, RATE PER 100,000 POPULATION AND PERCENT CHANGE IN RATE OF OPERATIONS PERFORMED FOR INPATIENTS DISCHARGED FROM SHORT-STAY HOSPITALS IN THE UNITED STATES, BY YEAR

	Number (thousands)	Rate per 100,000	Percent change in rate
Year:			
1971	15,774	7,805.3	....
1975	20,040	9,585.0	+22.3
1976	20,087	9,538.7	−0.4
1978	20,754	9,703.8	+1.7
1980	24,494	10,982.0	+13.2
1982	34,632	15,070.0	+37.2
Percent change:			
1971–1982	+119.0	+93.1	....

Source.—National Center for Health Statistics, Hospital Discharge Survey.

Small area variations in the type and rate of surgeries, in some cases counties side by side having 600 percent more operations in one county as compared to the other, has been clearly documented by Wennberg and others.

The Cornell-New York research program provided the impetus for proliferation of Second Opinion Programs across the country. And I am delighted to say at the present time, we estimate that approximately 15 to 20 million individuals have a mandatory Second Opinion Program in their health benefit package.

Our results have been disseminated in both the scientific literature—New England Journal of Medicine, Medical Care, Annals of Surgery, et cetera—and also in the proceedings of business, union and local government groups, such as the AMA, Business Coalitions, International Foundation of Employee Health Benefits, and cost containment seminars, etc.

The repeated results of our studies of over 50,000 second opinions in New York, Detroit, and the national-based second opinion programs which we just announced last month, in the last 14 years gives you the following results:

One, 14 to 18 percent of the individuals who were enrolled in a mandatory Second Opinion Program were not confirmed for the suggested surgery. Outcome studies, in other words we follow those individuals for as long as 5 years, indicated that two-thirds to almost 80 percent of the nonconfirmed group, that is the group that was not confirmed for surgery, never had the surgery.

All of the many companies and joint funds—and these are scores and scores of them now, in fact well up into the hundreds—who initiated a Second Opinion Program and experienced the sentinel effect, that is a 10- to 18-percent drop in their surgical claims, when compared to the level of surgical claims prior to program initiation.

Now, this sentinel effect is not a new phenomenon. It has been shown repeatedly in medical and sociological studies—that knowledge of the existence or a surveillance system influences the behavior of those being observed or monitored.

A surveillance system to monitor the hysterectomies in the Canadian Province of Saskatchewan, for example, found that the number of hysterectomies performed dropped by more than half—after a medical committee started monitoring the reasons for which the operations were performed. This was reported by F.

Dyke, et al., in the New England Journal of Medicine of June 9, 1972.

In January 1985, we announced the results of our National Second Opinion Program's having access to our network of 24,000 second opinion surgeons. Although five out of every six cases were confirmed for surgery, in 17 percent of those confirmed second opinions, the surgery suggested could be shifted from the hospital to an ambulatory facility, resulting in a substantial cost savings.

From 1975 to 1982, the Health Benefits Research Center at Cornell-New York Hospital analyzed the voluntary Second Opinion Program administered by the Blue Cross-Blue Shield of Michigan on behalf of Chrysler, Ford, General Motors, and the United Auto Workers. Their nonconfirmed rate was 30 percent and the cost-benefit ratio was 3 to 1. Since 1978 we have declared that the very low utilization in all the programs that we have undertaken and studied in other groups show only 1 to 3 percent of the eligible surgical patients in a voluntary program utilizes the program. And we have deemed the voluntary Second Opinion Program from the point of view of utilization review and cost-effectiveness to be ineffective. The Medicare demonstrations in Detroit and Medicare have confirmed the data on this particular point.

Now, mandatory programs, which require a consultation prior to elective surgery, have consistently demonstrated in the private sector of the United States an impressive cost-benefit ratio of $2.63; that is, for every dollar of cost incurred, there was a $2.63 benefit gain. Two-thirds of that cost-benefit was realized from the medical care savings and one-third from productivity gains.

Now, our recently announced study, which was January 1985, demonstrates that the cost-benefit ratio for the nine most common surgical procedures were quite dramatic: hysterectomies 11 to 1; prostates 8; bunionectomy 7; knee surgery 6; breast, et cetera 5.

I may add that although our statistical data was not available at that time on the coronary bypass, we found that the cost-benefit ratio was 25 to 1, which will be a supplementary study that will be published later this spring.

The shift of care from the high-cost center of a hospital to an ambulatory facility will offer to the Medicare population the deserved option of avoiding a hospital stay. This is an effective noncontroversial form of utilization review, with the focus of the decision in the hands of the Medicare patient. As the technological capacity to perform more elective surgical procedures in an ambulatory setting has progressed, the requirement for a Second Opinion Program affords the Medicare Program an in-place form of utilization review.

In conclusion, if the patient is made aware of the possible alternatives to surgery or is reassured that surgery is in his or her best interest, it is plausible that many procedures need not necessarily be performed and will not be performed. Mandatory second opinion consultation is designed to achieve just that objective.

The Second Opinion Program represents the first concerted cost-containment effort targeted directly at the individual consumer of medical care: the patient. The patient is naturally the final decisionmaker concerning his or her health care. Armed with this new benefit—a mandatory Second Opinion Program—the patient can simultaneously improve the quality of their care and significantly reduce the cost of surgical health care.

Chairman HEINZ. Dr. McCarthy, thank you.

Let me just ask you two questions. You have heard three stories today about people who have had near misses with surgery. They seem to be healthy, active. Indeed, they may even be better off for not having had all of that.

Are their case histories at all unusual?

Dr. MCCARTHY. No; they are typical of the thousands and thousands that we have studied.

Chairman HEINZ. Now, in your opinion, as somebody who has studied this area, this field of the medical researcher, with great care for some 14 years, as I understand it, do you believe that a mandatory second opinion would be beneficial to both Medicare and Medicaid?

Dr. MCCARTHY. Absolutely.

Chairman HEINZ. No doubt in your mind at all?

Dr. MCCARTHY. No doubt whatsoever. The evidence proves that.

Chairman HEINZ. Dr. Graboys, do you believe that a mandatory Second Opinion Program would be beneficial to the Medicare and Medicaid Programs?

Dr. GRABOYS. Yes, sir.

Chairman HEINZ. The people who would be most affected by that would be the three people on the panel.

Let me simply ask Mr. Penberthy, Mrs. Armstrong, Mr. Law: Assuming, of course, that the choice is left up to you, that you could ignore the second opinion if you wanted to, but if there was a mandatory second opinion required, do you think that that would be a good provision to put into the law, so that everybody avoided having to deal with the occult, as Mr. Penberthy said, worried about the authority of the doctor and just could say I have got to get a second opinion, I am going to do it, the law requires it. Would that be a good thing or a bad thing for us to do ? Mr. Law. Good or bad?

Mr. LAW. Well, I am not really sure. It depends on where you are located and what kind of medical facility is there.

Chairman HEINZ. So you are saying it might be inconvenient for some people?

Mr. LAW. Well, possibly.

Chairman HEINZ. What you are saying is it might be all right if there was a waiver of some kind for people who could not easily get a second opinion. Is that more or less your point of view?

Mr. LAW. Yes, I think that might do it.

Chairman HEINZ. Mrs. Armstrong?

Mrs. ARMSTRONG. I would approve of it.

Chairman HEINZ. You think that the mandatory second opinion, as I have described it, would be a good idea.

Mr. Penberthy.

Mr. PENBERTHY. Yes; I certainly would. But then, with the caveat that you have to be wary, that the second opinion is truly a second opinion. You do not want to get a second opinion from the partner of the man who gave you the first one. [Laughter.]

Chairman HEINZ. Care in all things.

Let me, at this point, turn to Senator Denton. Do you have any questions?

Senator DENTON. Well, if I may, I would like to make a general remark, because this is my first opportunity to attend such a meeting.

Chairman HEINZ. May I just say, in that regard, Senator Denton is a brand new member of the Senate Committee on Aging. He was appointed only last week. This is the first meeting of the committee. His attendance record is even better than mine, it is 100 percent. [Laughter.]

Welcome to the committee.

STATEMENT BY SENATOR JEREMIAH DENTON

Senator DENTON. Thank you very much, Mr. Chairman.

I previously served as the subcommittee chairman of the Aging, Family and Human Services Subcommittee, and then having had to drop that because of the new rule about three—or the enforcement of an old rule about having three A committees; I now have Armed Services and Judiciary, and this was the best I could do to get back into the care and concerns about our elderly.

We have the RSVP programs, the Older Americans Act, Foster Grandparents Programs, Meals on Wheels, all the various things that the Labor and Human Resources Committee handles; and it is a real pleasure to me, Mr. Chairman, and I want to compliment you for getting into an area which appears to be a scandal, really.

I am just learning from my mother, who is 81, these past 3 months that this problem is part of a larger problem. It seems to me that older people are being victimized in major ways. My mother is having problems with house insurance. She had this very expensive house insurance she paid for 45 years, now something has gone wrong with her roof and they informed her that because she has reached a certain age, sorry about that, they are not going to carry the insurance any more, and retroactively, 6 months ago or something like that, it was automatically terminated. And there is nothing that she can find in there to tell her that, you know.

She has the most expensive health program in the country, and yet they are not going to pay her $450 worth of medical bills that she incurred, and she is about to have a nervous breakdown about both of those things.

And here we are—correct me if I am wrong—in this field, it seems that at the minimum we have established that with respect to recommendations resulting in coronary artery bypass surgery we have at least loose criteria, resulting in too many such operations, No. 1.

No. 2, we have a drastic disproportion in that throughout the United States, from place to place, there is an apparent concentration according to this information, the summary of findings. Has that been revealed yet, Senator?

Chairman HEINZ. That is just a staff summary for members only.

Senator DENTON. OK. Among other things, hysterectomy is performed 80 percent more often in the South than in the Northeastern United States—300 percent more often in one local area in Vermont than in any other area in that State.

In Massachusetts, the likelihood of hernia repair surgery varies by as much as 380 percent from one region of the State to another, while pacemaker surgery varied by as much as 1,250 percent among regions of the United States.

Well, to me that indicates that there is indication that within certain areas of the United States there is a peculiar propensity for over-prescribing operations, maybe to a rip-off degree, to state it mildly.

The Second Opinion Program mentioned by Dr. McCarthy seems to be a very valid way of getting at the program. I imagine the chairman was talking about something legislative. Could the hospital people, you know, the doctors, hate to be told what to do by the Federal Government—I have learned, as we went through the *Baby Doe* bit. Could you all have within the AMA a compulsory Second Opinion Program, such as the one you instituted yourself, Dr. McCarthy, without legislation?

Dr. McCARTHY. I think that the historical precedent indicates that probably the answer to that is no. What I think is important is that private industry—the motor companies, many of the big corporations, defense industry, many of the union joint trust funds, which were the real movers of this way back in the early seventies—have found value in this program, and it is growing dramatically in the private sector. So I think it is really a question of bringing in the fruits and harvesting of their findings to your table, for your digestion in terms of its value to the aged.

Senator DENTON. Mr. Chairman, I would ask you then, if you decide that, as a result of the testimony, we should have legislatively required mandatory second opinion, how would you bring that into being, since we are not mandated to introduce legislation?

Chairman HEINZ. Senator Denton, as a Member of the Senate, if I decided that this is a good thing to do by virtue of this information or any other information I have, I suppose what I would do is write legislation, circulate it, in particular, to members of the Aging Committee, who I think have a great interest in this, pending the outcome of our testimony, and give other Members of the Senate a chance to join in cosponsoring that. Such legislation would undoubtedly be referred to the Senate Committee on Finance, on which I am privileged to serve, I serve on the Health Subcommittee of the Committee on Finance, and it might or might not be necessary to have further hearings there. If you looked at the tax bill we presented you with last year, and if you did look at all of it, you were indeed an unusual Senator, because it ran to several hundred, even a thousand pages; we do not always have hearings in the Finance Committee on everything that we report. This may be a shock to many. But if we do a good enough job in this committee, establishing the legislative record, that we would hopefully save the Finance Committee additional hearings.

We have the luxury of being able to specialize in health care areas, that the Finance Committee under pressure could produce a lot of budget savings, to consider tax reform. It is not always possible for them to direct all the time and effort that goes into preparing for a hearing like this.

Senator DENTON. Well, I volunteer, Mr. Chairman, to help you in any way I can, and with my staff, because I believe you have your finger on an area which definitely requires corrective action, and I wish you well in your pursuit of it.

I, like Senator Glenn, we have two Armed Services Subcommittee hearings going on, which I am supposed to be at, I will not be able to stay longer. But, again, congratulations on this, and I want to thank the witnesses for their very enlightening testimony to me, and I will be reading the record of the rest of your hearings, Mr. Chairman.

Chairman HEINZ. Very well. Senator Denton, just let me say that I appreciate your questions, and I assure all members of the committee that I intend to work very closely, not only with you, given your great interest and experience, but all the members of the committee who have an interest in this area, so that we work together, not individually or separately. Thank you.

Senator Dodd.

STATEMENT BY SENATOR CHRISTOPHER J. DODD

Senator DODD. Thank you very much, Mr. Chairman.

Let me congratulate you as well. I think these are excellent hearings. I apologize for being a few minutes late.

It is a pleasure to be back as a member of this special committee. We have had some good hearings in the past, and I am looking forward to more of them in the future. You know, like anything else, the presumption, I guess, is that Members of the Senate or the body here do not always have the same kinds of problems that witnesses do.

Just coincidentally, I have a sister who was born legally blind. She is a little bit older than I am. She just went through one cornea transplant about 6 months ago and the graft did not take. We went through the terrible decision last weekend, my family, my brothers and sisters; she had to go back in for another cornea transplant, but she had had serious infection; and the question was whether to deal with the infection in one operation and then wait for a cornea to become available and go through a second operation. It went all weekend back and forth, trying to get different opinions on whether or not she ought to go through surgery once or twice, whether you wait or not. It is a terribly agonizing decisionmaking process to go through. Finally, she was able to get a cornea and went through the operation on Sunday night. Apparently things are moving well, although with some caution, because you need some time in an operation like that. She has terrific physicians dealing with her. So I am particularly interested in this discussion of the whole question of second opinions.

One of the things I would like to just pursue with you a little bit, and ask the physicians as well as the—I guess the physicians more than the patients: Part of the problem was that I have heard over and over again, is the resentment of physicians when a patient suggests they would like a second opinion. That somehow the physician offering the opinion is not competent, that you do not trust him, that you do not have any confidence in them. How widespread is that?

You hear of it often, and that can be awfully discouraging. You are in such a fragile position mentally, frightened over the possibility of surgery, and you place a great deal of trust, I think patients do, in physcians; and when that physician begins to make you feel uneasy, because you suggested that you would like to have someone else give you an opinion, it can be awfully debilitating. What else might be done?

We are talking here about mandatory second opinions. Is there something else that might be done in order to encourage the medical community to accept the notion of second opinions; or am I exaggerating the problem?

Dr. **Graboys**. Well, I do not think you are exaggerating the problem, Senator. I think it is a real issue, because, particularly in heart disease, the fundamental trust that is established between the physician and the patient when you are dealing with affairs of the heart are a little different than if you are talking about an elective hernia repair, for example.

For example, of the patients who came to see us, virtually 90 percent of them were self-referred. These were not patients who were referred by other physicians. In fact, there was a good deal of unease on the part of the primary physician, primary cardiologist, and a certain amount of resentment about our conclusion that a given individual did not need bypass surgery, for example.

I think part of the issue, as it relates to bypass surgery, is education. With the increasing acceptance that medical therapy is effective and with newer means to treat patients medically, I think it is going to be extremely helpful in decompressing the primary-care physician and the general internist from his or her own angst in dealing with a cardiac patient, and that will, in turn, reduce some of the referrals to the cardiac catheterization specialist, for example.

Senator **Dodd**. Did you do any followup surveys, to determine whether or not the primary physician and the patient had a recurring relationship after the decision to take a second opinion? What happens between that patient-physician relationship?

Dr. **McCarthy**. Basically, nothing. I am going to take a little different tilt, because we have observed this now for several years. I really cannot answer your question. I think the problem, basically: In our programs and in the programs around the country with mandatory Second Opinion Programs, we have at least half of the individuals ask on their own initiative, these are the patients, not to inform their physicians.

They ask the second opinion group, who is arranging the appointment and giving them a choice of other doctors to see in that particular specialty, "Do not let my personal physician know that I am going to a second opinion." In monitoring second opinions since 1971, we have consistently observed this behavior.

I think it reflects the fact that the individual feels very consciously that he or she wants to maintain a good relationship with their personal physician. At the same time, they would like and enjoy the possibility of getting a broader prospectus on this.

Interestingly enough, though, when I act as somewhat of a midwife here, because many times we have to obtain studies and diagnostic workups from the first doctor. When the patient goes in to see the second opinion surgeon, regardless of what particular surgery is suggested, if he suggests to the patient that "I would like to see the gallbladder studies, I would like to contact your first physician," the patient at that time, for some reason, has no inhibition whatsoever to give permission to do this.

And, finally, we have monitored tens of thousands of second opinions, I have never had a personal physician take objections to being contacted by another doctor, who the patient initially has sought out for himself or herself, namely, to participate just as actively and as cooperatively as he would if the second opinion had been suggested by a colleague or another physician.

So I think the perception of the public is that the physician would react quite negatively and rupture that umbilical relationship. Now, whether that is true or not, there is no evidence to indicate it.

Senator DODD. Well, did you ask those questions of the patients?

Dr. MCCARTHY. We have asked the questions, and the patients consistently come back with, regardless of what part of the country we are talking about, that they would prefer initially not to have their doctor know.

Senator DODD. Well, what do you conclude from that?

Dr. MCCARTHY. I think that they are nervous that the physician would take some form of reprisal if they knew that they were about to have a second opinion. But I just wanted to emphasize that our evidence indicates that has never taken place.

Senator DODD. Yes; the reprisal has not?

Dr. MCCARTHY. No; that is right.

Senator DODD. But do you have any information, does your data suggest at all that the primary physician has indicated in some way that if the patient were to seek second opinions, that they were somehow lacking the kind of confidence in them that they ought to have?

Dr. MCCARTHY. No, we do not have any data on that basis; but, I think the Second Opinion Program, Senator, rests on the fact that it gives the patient the option, without—in other words, there is a new door that they can go through in order to get a second opinion, they do not have to run the risk of jeopardizing their relationship with their personal physician.

Senator DODD. I see my time—are we following the clock?

Chairman HEINZ. We have two more panels of witnesses.

Senator DODD. May I ask just one other question? I was not here when you mentioned this, Dr. Graboys, but I understand you said that, in a particular case, you did not recommend medical treatment as opposed to coronary bypass surgery for a patient where there was a great deal of tension at home, where the patient's spouse thought that every breath that a person drew would be their last.

Did you recommend surgery in those particular cases, where there was that tension?

Dr. GRABOYS. If we felt that, despite all of our reassurance, that the patient was going to do fine, and we would meet with both the patient and the patient's spouse; or, in some cases, the whole family. In that individual, if our Gestalt was that we could not decompress the situation, if we felt the family was going to be living with a sword of Damocles hanging over them, then we would say, "Listen, we would recommend surgery because your symptoms are such," and, in addition, particularly when it relates to heart disease, you just cannot isolate the heart, because you are sitting here alone.

There is just a whole welter of psychologic factors that come to bear on how a given individual does, and it also impacts on the relationship of the physician with that patient, because ofttimes, if the patient would go back to the original physician, we have had instances where the physician has said, "Listen, I do not feel I can take care of you because I feel that you should have an operation, and I do not feel comfortable continuing to manage you medically; I think you should find another physician."

Senator **Dodd**. I presume in dealing with that problem, you have certainly tried to come up with a variety of ways of reducing the amount of tension and fear the patient would have, or the spouse might have, of that sword of Damocles, as you described it. Is there not a tremendous bias, given all the notice of the Schroeder cases and so forth, that not only is there suggestion of a bias maybe in the medical community for surgery, but a growing, a tremendous bias within the patient community for surgery?

And what might we do? There are things other than legislation to contribute to easing of some of that tension, more promotion of cases, possibly, where the medical treatment rather than the surgery was tremendously successful.

All the programming, all the new shows we see are ones that involve surgery, and I suspect that that tremendous groundswell of support for that option has an awful lot to do with the tension that you are getting out of some patients.

Now, this is just a personal layman's opinion, but would you agree or disagree?

Dr. **Graboys**. It is a major educational effort that is necessary. Unfortunately, the media picks up on what is sexy and what is seductive. That is the technology of medicine. It is not particularly newsworthy or of news interest, when we sit down and talk to a patient for an hour about going back on an exercise program or stopping smoking or altering their lifestyle. It is old hat. But all the gadgets and gizmos and LED displays that we have in modern cardiology are very seductive, and I think that is part of the problem.

Senator **Dodd**. I think I agree with you on that, too.

Thank you, Mr. Chairman.

Chairman **Heinz**. Senator Glenn.

STATEMENT BY SENATOR JOHN GLENN

Senator **Glenn**. Thank you. I apologize I was not able to be here at the start, Mr. Chairman and our witnesses. We have had other committees meeting this morning and, unfortunately, I had to be there; so I am sorry I could not be here earlier. I am pleased that the Senate Special Committee on Aging is holding this hearing to examine the merits of mandatory Second Surgical Opinion Programs [SSOP's]. Since 1977, Americans have heard a great deal about the positive results of seeking a second opinion before undergoing certain types of elective surgery. This has been particularly true for specific procedures such as tonsillectomy, cataract removal, dilation and curettage, gallbladder removal, hysterectomy, knee surgery and prostatectomy, to name a few. We are learning that Second Surgical Opinion Programs are successful in avoiding the risks surgery entails and in finding alternative methods of quality treatment, as well as in reducing medical costs.

In our continuing struggle to contain rising health care expenditures, we often hear that the usual laws of supply and demand do not work in the medical care market. It is customary that when a person's doctor recommends a procedure, the patient will follow the doctor's advice. Today, we have representatives from private businesses telling us that SSOP's for selected types of surgery bring old fashioned competition into the health care marketplace. When patients receive more information, the traditional laws of supply and demand can begin working.

Second surgical opinion programs help patients become more intelligent consumers of medical care services because they learn more about alternative methods of treatment. This appears particularly true—given the experience of the private sector—when a second surgical opinion is mandated by an individual's insurance plan. In this situation, a person seeks outside advice, without questioning his or her doctor's opinion, because such information is mandated for health insurance benefits.

We are now living in a time when there is a wide variety of treatment options for certain kinds of elective surgery. Individuals need to exercise caution in choosing the care most appropriate for them. This is particularly true for Medicare beneficiaries as surgical procedures pose increased risks for older people. This latter concern is of special interest to me as the ranking Democratic member of the Aging Committee. Therefore, I look forward to reviewing today's testimony with an eye toward how it might be applied to the Medicare Program.

I want to express my appreciation that we have a witness from Ohio here this morning. William J. Sheehan, vice president for personnel of the Dana Corp. in Toledo, OH, is testifying before the committee. Mr. Sheehan also serves as president of the Toledo Business Coalition on Health Care, a group whose membership includes 20 major companies based in Toledo. The Dana Corp. requires second surgical opinions in its health plans for employees and retirees. Nine member companies of the Toledo Business Coalition on Health Care have added SSOP's to their health plans in the past 2 years. I look forward to the benefit of Mr. Sheehan's testimony.

At this time, I will also ask that an article by Richard J. Hanley, vice president of health care policy and programs at Owens-Illinois, Inc., be inserted into the permanent hearing record following the testimony of the witnesses. Owens-Illinois is a member of the Toledo Business Coalition on Health Care. In 1983 alone, the company estimates that it saved $300,000 through its second surgical opinion program for selected surgery. Mr. Hanley's article, written with Jacquelyn T. Ayers, describes the success of this program. It was published in the March 1985 edition of Business and Health and is titled "Second Opinion: A Tool to Save Money, Improve Care."[1]

As Mr. Hanley points out, one important feature of the Owens-Illinois program is that it preserves each patient's freedom of choice. However, when people learn that they can avoid the operating table, they listen. I believe that the true value of Second Surgical Opinion Programs lies in informed freedom of choice. Increased patient involvement and education promotes understanding, choice, and hopefully, the selection of the most appropriate form of care. But just a couple of questions here, before we get on to the next panel.

In seeking a second opinion, you talked about going back and getting the data, the workup from the first doctor. Are those always valid, or is some of the difference in that you, as a second opinion giver, would actually want to do your own workup and would get a different result from that? In other words, is an honest opinion based on data that changes or would be different? Are all the workups valid, I guess is what I am asking.

Dr. McCarthy. Senator, it is a mixed bag; but you are quite correct, that many times the second opinion offers a repeat of a study, a gallbladder study that is more definitive and gives a much clearer direction of the prudent course of action to take.

Senator Glenn. Yes; do you use any peer review in cases like this? In other words, do you have doctors that are particularly flagrant violators—where they are cutting doctors, they want to get into the surgery and go. And they are more prone to recommend surgery than others might be who would say there are some alternative things we ought to look at here, and let us check this again. Do you find in peer review of doctors some who are particularly flagrant in their violations of recommending surgery where it probably should not be recommended?

Dr. McCarthy. Well, up to now we have not done any particular studies. We are embarking on a study now to look at what we call the profile of particular groups of surgeons.

One of the problems, Senator, has been to get the numbers, to get thousands upon thousands of examples of cataracts and hysterectomies, so you really have some statistical validity in terms of this.

But the program really hinges on the fact that the patient enjoys the opportunity of getting a second opinion, a broader prospectus. I think one of the really outstanding features of this is that we offer a free third opinion, and you would think there would be a good use of that particular benefit, a tiebreaker, so to speak, a yes-no type combination; but, in monitoring over 128,000 second opinions, we have yet to have 500 third opinions.

So there seems to be a degree of satisfaction at the second opinion, that the options are there.

Senator Glenn. What I was trying to do, I guess, was cut out some of the problem, short of the patient, his or herself. If there are certain doctors who are recommending things that should not be done, we ought to try to weed them out so less second opinion is necessary, I guess is what I am saying.

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[1] See appendix p. 298.

Does anyone else wish to comment on this?

Thank you, Mr. Chairman.

Chairman HEINZ. Senator Glenn, thank you.

I have six questions for you, Dr. Graboys, that I would like to submit for answers in writing, if you would be so kind, in the interest of time.[1] I am sure you are extremely able and competent to answer them.

If there are no other comments or questions, I would just like to thank this panel.

Mr. Penberthy.

Mr. PENBERTHY. There is a good deal of interest here in second opinions. I happen to be an expert in the field of nuclear waste disposal. And I am doing my best to give my second opinion to the Department of Energy on how this should be done. The objective is to save $1 billion a year for 20 years. And the problem is to get the patient, the Department of Energy, to even listen to this second opinion. I have an appointment with your staffer, Dwight Holtz, this afternoon at 1 o'clock, and I hope that you will take some interest in my second opinion that will save $1 billion a year for 20 years. [Laughter.]

Chairman HEINZ. It sounds like it is mandatory that we take interest in that second opinion, too. [Laughter.]

All right. Thank you all very much. We appreciate your being here.

Would the witnesses on the second panel please take your seats?

We are pleased to welcome you.

By way of introduction of our next panel, Mr. Norman Harberger is the vice president of administration for the Rohm & Haas Co., headquartered in Philadelphia, PA, and is chairman of the Pennsylvania Chamber of Commerce Health Care Subcommittee; Mr. William J. Sheehan is vice president of the Dana Corp. and president of the Toledo, OH, Business Coalition on Health Care—Senator Glenn asks that I repeat that it is the Toledo, OH, Business Coalition on Health Care; Mrs. Vita Ostrander is the president of the American Association of Retired Persons; and Richard Kusserow is no stranger to this committee, inasmuch as he is the inspector general for the Department of Health and Human Services.

Mrs. Ostrander and gentlemen, you have each submitted prepared statements for the record. In the interest of saving as much time as possible, I would ask you to summarize your statements, keep them brief, and your entire statements, of course, will be a part of the record. We do want to have time for questions.

We have one other panel of witnesses. We ran a little long, I apologize, on the first panel.

Let me ask, Mr. Harberger, would you please proceed; and welcome.

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[1] See appendix p. 301.

STATEMENT OF NORMAN P. HARBERGER, VICE PRESIDENT OF ADMINISTRATION, ROHM & HAAS CO., PHILADELPHIA, PA

Mr. Harberger. Good morning, Senator. Thank you for giving me the opportunity to speak with you this morning. The perspective that I bring is out of the private sector, both in my position as vice president for administration of a medium-sized company and also as the chairman of the health care committee for the Pennsylvania Chamber of Commerce.

The conclusions that I have drawn out of those perspectives could be summrized like this:

There is, without question, a great deal of unnecessary surgery.

Surgery does pose special risks for older people.

Second opinions, by averting unnecessary surgery, can save money and save lives.

Patients are reluctant to ask for second opinions on their own, even when they harbor some doubts about their initial doctor's opinion.

Mandatory second opinions get around that problem; they deal with that reality. They are becoming a much more common feature, both in employee benefit plans of private employers and in State laws.

So, I strongly endorse the idea of incorporating a selected second opinion requirement in Medicare and Medicaid.

Now, let me elaborate a little bit.

If second opinions were uniformly required, prior to all surgery across the board, regardless of the procedure, you would get a nonconcurring opinion about 10 percent of the time. But that is a misleading number, because there are quite a number of surgical procedures where there is relatively little disagreement, and there are a number of other procedures where the disagreement occurs 20 percent, 50 percent, or even more of the time.

Owens-Illinois has had a mandatory Second Surgical Opinion Program in their employee benefit plan for a while now. They require second opinions on 13 selected surgical procedures, and they have found that they get nonconforming opinions in about 40 percent of all the breast and back surgery cases, 50 percent of the varicose vein cases and about 10 to 20 percent of hysterectomy, tonsillectomy, prostate, knee, and gallbladder cases.

Owens-Illinois does not happen to include—I do not know why—coronary bypass and cataract surgery among the procedures on which they require second opinions, because those procedures also have been found in other studies to be subject to high percentage of disagreement, as I think has been given evidence in the first panel.

The basic point is that when it comes to certain kinds of procedures, the degree of disagreement among doctors is significant. Obviously, some of the procedures I mentioned are especially likely to involve older people—cataract surgery and prostate surgery. And even in those procedures where older people are not more frequently involved, older people are at greater risk. This is true for surgery of any kind, particularly if it involves general anesthesia.

So, I think it is particularly important to try to avoid unnecessary surgery for people who are at unusually high risk.

Now, we have had in my company a voluntary second surgical opinion feature in our employee benefit plan for a number of years. We will pay for the second opinion if the employee seeks it. It is very rarely used. People are hesitant to appear to be questioning the competence of their physician. They are more hesitant to ask for second opinions than the doctors are hesitant about authorizing a second opinion. Doctors are much more forthcoming about blessing a second opinion than people think they are.

The folks you heard on the first panel who were so bold as to seek a second opinion are rare. That is where mandatory second opinion comes in. It really gives us a crutch to go ahead and get a second opinion without feeling we are insulting our doctor.

We recently negotiated our first mandatory second surgical opinion in one of our union labor agreements. And we were told by the union leadership that employees are far more comfortable requesting a second opinion, because their insurance requires it than because they are personally doubtful about the first opinion. And that is what you are dealing with in terms of the psychology of the situation.

The Health Care Committee of the Chamber of Commerce of Pennsylvania is working on a comprehensive program to try to develop more cost-effective health care delivery for the people of the State. We are working with the Hospital Association, the Medical Association, Blue Cross-Blue Shield, the commercial insurers, and we are coordinating our work with labor leadership. All of those interest groups are of a mind, when it comes to taking steps that will reduce unnecessary utilization and reduce unnecessarily risky treatment, and that includes the Medical Society.

We will be recommending legislative action at the State level to require second surgical opinions in a select group of procedures. Ten States now have such laws, so this is by no means unusual. And I think there is broad public support for this kind of action.

Recommendations for getting increased cost effectiveness in health care really take one of two paths—they either call for an increasing overlay of regulatory measures or they call for an increasingly, well-informed, competitive health care marketplace. And I strongly favor that latter course.

If we want a health care system that is of high quality and cost-effectiveness, we really have to create conditions where people who need care and folks who pay for the care have the information they need to be smart consumers. Now, that includes information about what care it is that they really need and about any alternative means of treatment and about the quality and price of the services that are available from the potential providers. We have a long way to go before we arrive at those conditions. A lot of customs are going to have to change. But the provision of a mandatory second opinion for selected surgical procedures is a step in the right direction. It will result in better information about the need for care and about alternative means of care.

I strongly urge you to incorporate mandatory second opinions for selected surgical procedures in Medicare and Medicaid.

Thanks again for letting me speak to you.

Chairman **Heinz**. Mr. Harberger, thank you very much.

Your company, Rohm & Haas, has been one of the real leaders in so many things having to do with the health care industry; we commend you for the work you are doing, both as a company and as a concerned individual. We thank you very much.

I would like to yield to Senator Glenn, to introduce our next witness.

Senator GLENN. Thank you, Mr. Chairman.

I want to express my appreciation for our witness here from Ohio this morning, Mr. William J. Sheehan, who is vice president for personnel of the Dana Corp. in Toledo. Mr. Sheehan also serves as president of the Toledo Business Coalition on Health Care, a group whose membership includes 20 major companies that are based in Toledo and the Toledo area.

Dana requires second surgical opinions in its health plans for employees and retirees, and nine member companies of the Toledo Business Coalition on Health Care have added SSOP's to their health plans in the past 2 years.

So, Mr. Sheehan, we welcome you this morning, glad to have you here, and look forward to your testimony.

STATEMENT OF WILLIAM J. SHEEHAN, TOLEDO, OH, VICE PRESIDENT, DANA CORP., AND PRESIDENT, TOLEDO BUSINESS COALITION ON HEALTH CARE

Mr. SHEEHAN. Mr. Chairman, Senator Glenn, thank you for the opportunity to testify before this committee.

Once again I want to repeat for all that Dana is a Toledo, OH, based corporation, and we have approximately 27,000 employees in the United States, and 37,000 around the world.

I would like to give you just a little bit of the background about the coalition. We were formed in late 1981, and dedicated to containing health care costs for employers and employees without sacrificing the quality or essential health care needs.

When the State of Ohio terminated health planning in 1982, the coalition was instrumental in establishing and supporting a local voluntary planning body, Northwest Ohio Health Planning. Now, that body has provided input on community needs for expansion and use of medical facilities and has played a major role in averting significant capital expenditures at two hospitals in our community.

Now, with the reinstatement of health planning in Ohio, it has been designated as the Health Planning Agency in the 11 counties of northwest Ohio.

Early on, as a coalition, we began a dialog with the local academy of medicine; for although hospital costs have been the major factor in overall soaring health care, doctors have been the ones who make the decisions affecting medical services. But we were not pointing the finger of blame at any one sector, we are all to blame: The Government for its reimbursement in tax policies; business and labor for benefit plans which encouraged employees to regard health insurance as a freebie; and the medical community for its utilization policies.

Now, in response to our concern—and this also is in response to something that you, Senator Dodd, inquired about earlier, as to whether or not anything was being done about physicians—there was a special business-medicine committee established, in cooperation with the Blue Cross of Northwest Ohio, they began working on physician practice patterns. As a result of this, hospital days per thousand have dropped in our area from 837 in 1982 to 660 by the end of 1984.

While undertaking an awareness and education program for hospital trustees, at the same time our coalition member companies began working to inform and involve the people in their own companies, the benefit plans were revised and, in the process, employee awareness has been heightened by the sharing of costs. But there has been no single best way to accomplish this. Each company has tailored the approach to its own specific needs.

As coinsurance and deductibles and incentives for the use of outpatient services were constructed, requirements for second surgical opinions surfaced as a tool for employee involvement, and for cost containment. Since people frequently—and as we have discussed that here in this panel this morning—since people frequently were reluctant to question their doctors, a mandatory second opinion on certain elective procedures was often required.

In Dana, we have included this in some 61 locations. Now, we are a very decentralized corporation and each of our divisions will develop their own benefit plans, their own compensation programs related to their own area; but, in 61 of them, second surgical opinion has been installed with few adverse comments.

Some of the plans apply to retirees and some do not; some to retirees after a certain date, and some only to those under 65. Six of our member companies have included it in union contracts, and one, only in the local union contract; another does not have it in a contract, but they do have union approval.

While we find it too early to provide any comprehensive data, one of our coalition member companies who was mentioned here this morning, Owens-Illinois, has reported in an article in Business and Health magazine a first-year cost savings of $300,000.

But more than just cost containment, we do believe that second opinion has provided an opportunity to improve the quality of care. Because even if the opinion is confirmed, often the setting can be changed from a hospital to an outpatient setting. And then the infection complications suffered by hospital patients can be avoided. Such complications, called Nosocomial infections, have been termed in the American Journal of Epidemiology of just last month, serious public health problems.

A sample-based estimate shows there are substantially more such infections each year than hospital admissions for cancer or for accidents, and four times more than admissions for acute myocardial infarction. I guess that means heart attacks.

Apparently, hospitals can be hazardous to your health.

To conclude, in our opinion, second surgical opinions will soon be an ordinary part of employee benefit plans. We think they will work to hold down costs and to improve the quality of care.

Once again, thank you for this opportunity.

Chairman HEINZ. Thank you very much, Mr. Sheehan.

Our next witness is Vita Ostrander, who is not unfamiliar with the committee, nor us with Vita, for the excellent work she has been doing in so many areas, as president of the American Association of Retired Persons.

Vita, thank you for being here. We are delighted to have you. We are fortunate to have you.

Please proceed.

STATEMENT OF VITA OSTRANDER, WASHINGTON, DC, PRESIDENT, AMERICAN ASSOCIATION OF RETIRED PERSONS

Mrs. OSTRANDER. Well, you always rope me in when I am in town.

I want to thank you, Senator Heinz, for inviting us to present our views on the Second Opinion Program.

Like you, my association has been studying Second Opinion Programs and firmly believes that the development of such a program for Medicare offers significant benefits to both beneficiaries and the hospital insurance trust fund, as well as improved administration of the Medicare Program.

The association's commitment to Second Opinion Programs is reflected in its own employee's health insurance plan, which incorporates a second surgical opinion requirement. As you can see, AARP, like other private-sector employers, believes second surgical opinion programs work.

Over the past decade or so, we have learned a great deal about how health care providers practice in this country. We know, for example, that the United States has the highest rate of surgery in the world and the highest ratio of surgeons to population in the world. Thus, it should not be surprising that the rate of elective surgery in the United States is increasing three to four times faster than the growth in the population.

We know, too, that a great deal of the surgery being performed is inappropriate and unnecessary. Although there have been many whose research elucidates this problem, the work of Dr. John Wennberg on small-area variations in physician practices clearly shows that unnecessary surgery occurs on a regular basis.

Moreover, his analysis of the DRG categories shows that there is a huge amount of practice variation within each DRG. If those variations are not appropriately reduced, policymakers will miss the most important opportunity for achieving meaningful savings in the Medicare Program.

AARP believes that an appropriate Second Opinion Program for Medicare could save hundreds of millions of dollars by reducing practice variations within specific DRG's. It would improve the ability of peer review organizations to monitor quality and utilization, and provide an improved and more flexible benefit to Medicare beneficiaries.

Permit me to elaborate on these points.

First, on savings of hundreds of millions of dollars, AARP is satisfied that research, such as the Cornell University project and the experience of private health insurers administering Second Opinion Programs, demonstrates that second opinions save money. The Cornell study showed that inpatient elective surgery was not confirmed in 20 percent of the cases with a second-opinion consultant. Concentrating the Second Opinion Program on a few high-cost, frequently performed procedures increases the rate of nonconfirmed cases to 25 percent.

The Prudential Insurance Co. of America estimates that targeted elective surgical procedures are reduced 15 to 20 percent under their incentive Second Opinion Program, reducing total plan expenditures by 1.5 to 2 percent per year.

Second, improvement in the quality of PRO organizations to monitor quality and utilization. Under current law, PRO's are required to monitor quality and utilization specifically through preadmission screening. This procedure is a paper review by the PRO, not a hands-on examination by an attending physician. Naturally, neither the patient nor the admitting physician will be happy with a denial resulting from such a review; hence, the PRO will end up spending an inordinate amount of time responding to appeals fostered by this paper review process.

A Second Surgical Opinion Program would relieve the PRO's of the necessity of screening elective surgery candidates. This would allow the PRO to concentrate on other review responsibilities and thereby improve their ability to monitor quality and utilization.

Third, the improvement and greater flexibility and the benefits provided to beneficiaries. A Second Opinion Program, freeing up of the PRO, provides a better benefit to Medicare beneficiaries, because it gives them a second hands-on analysis of their situation and a second opinion of the necessity of having surgery. Properly structuring a Medicare Second Surgical Opinion Program would provide beneficiaries with greater flexibility in exercising their rights concerning personal health care decisions.

AARP firmly believes that a properly structured Second Opinion Program for Medicare would be a significant improvement over the current law.

Let me give you some things that must be included in a Medicare Second Surgical Opinion Program:

One, the program must be mandatory.

Two, the second consultation must not involve any additional out-of-pocket cost to the beneficiary.

Three, the second consulting physician should not be financially involved with the referring physician.

Four, the second consulting physician must not be allowed to do the surgery if such is indicated.

Five, the second consultation must be waivable in situations of real hardship, where a second consultation is not readily available.

Obviously these elements are not an exhaustive list of all the things that might be put into a legislative proposal. My association would welcome the opportunity to work with you and your staff to fashion a legislative proposal in this area, and to seek its enactment into law.

We believe that a carefully structured Second Opinion Program for Medicare can yield improvements in the quality of medical care, and at the same time, achieve major savings in the Medicare Program.

Thank you for this opportunity.

Chairman HEINZ. Mrs. Ostrander, thank you very much.

Mr. Kusserow.

STATEMENT OF RICHARD P. KUSSEROW, WASHINGTON, DC, INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. KUSSEROW. Thank you, Mr. Chairman.

I am Richard P. Kusserow, the inspector general for the Department of Health and Human Services; and with me today is Arthur Rafalko, who is regional inspector general for audit in region III, which includes not only the District of Columbia and adjacent States, but is headquartered out of Philadelphia, in your State, Senator; and also is Tom Robinson, who oversaw, as audit manager, the study which the charts reflect.

We would like to thank you and the committee for the opportunity to present our reasons for recommending that mandatory Second Opinion Programs for elective surgery be adopted as a Government requirement for Medicare and Medicaid; I would like to take advantage of your offer and submit for the record my prepared statement, and verbally abbreviate it for your review.

Chairman HEINZ. Without objection, so ordered.

Mr. KUSSEROW. In 1982, our office began an independent review of second surgical opinion programs, to see what effect they were having on the number of elective surgeries being detained by patients in Medicare and Medicaid. We wanted to know whether or not such programs reduced the incidence of surgery and, if so, what type of programs worked the best.

Like Congress, we have had long concern that unnecessary surgery is wasting American lives and dollars and, based upon our analysis of available data, including those listed on the charts, we concluded that Medicare's voluntary Second Surgical Programs were not having the desired effect. But State Medicaid programs that required second surgical opinions were reducing the numbers of elective surgeries. Dr. McCarthy, testified about two of the listed studies moments ago.

Our review has convinced us that second surgical opinions are good for the patients as well as being good for the Department's programs. Beneficiaries are provided with information that they need to make intelligent decisions about elective surgery, and, as a result, tend to have more confidence and peace of mind about those decisions.

To the extent that some of our beneficiaries decide against unnecessary or only marginally necessary surgical procedures, because of the second opinion they benefit in ways that really are not measurable; that is, in terms of reduced anxiety about the pain, or pain resulting from the surgery, as well as the risk that comes from surgery.

Considering only nine elective procedures being included in second opinion programs, we estimated that $60 million a year could be saved in Medicaid if all States were required to implement such a program.

I would also point out, Mr. Chairman, that our nine procedures did not include two of the significant procedures that have been mentioned this morning: The pacemaker implantation and coronary artery bypass surgery.

We estimated that mandatory second surgical opinion for Medicare could save as much as $90 million a year, again depending upon what elective surgical procedures would be included.

So, the overall savings, conservatively, could be well in excess of $150 million for both programs.

For all of the foregoing reasons, we, therefore, recommended in our March 1983 report that the Health Care Finance Administration take whatever steps necessary to require mandatory Second Opinion Programs in both the Medicaid and Medicare.

With your permission, Mr. Chairman, I would like to submit a copy of our request on this subject for the record.[1]

Chairman HEINZ. Without objection.

Mr. KUSSEROW. To date there has been no mandatory second surgical opinion program for Medicare, and only four States, Tennessee, Oregon, Virginia, and Minnesota have been added to the original seven that decided to require it under Medicaid. Our conviction is that mandatory Second Surgical Opinion Programs are needed to reduce the rate of elective surgery is strengthened by the growing list of supporting studies, and by the increasing use of this type of program in the private sector.

As you can see from the charts, this concept has been studied extensively. The findings are and continue to be consistent on at least two central points: One, there continues to be the feeling that program participants are unlikely to obtain second opinions under voluntary programs; and, second, mandatory programs are cost effective. The two studies published subsequent to ours further confirms our findings.

The Cornell study, published in November 1984, concluded that, for each of the 11 procedures examined, benefits exceeded costs and that the mandatory program resulted in savings of $5.63 for every dollar spent.

The last study on the chart is still in draft. This is the ABT Associates' report which reexamines four Second Opinion Programs in Medicaid and Medicare.

Mr. Chairman, the ABT report also supports our view that mandatory second surgical opinions for elective surgeries could reduce the number of elective surgeries in Medicare and Medicaid; could reduce unnecessary risk for beneficiaries; and would result in considerable savings for our programs.

This concludes my opening remarks, Mr. Chairman; I will stand by for any questions.

Chairman HEINZ. Mr. Inspector General, thank you very much. Your prepared statement will be entered into the record at this point.

[The prepared statement of Mr. Kusserow follows:]

PREPARED STATEMENT OF RICHARD P. KUSSEROW

Mr. Chairman and members of the committee, I welcome this opportunity to appear before you today to discuss our views on the potential for a mandatory second surgical opinion program to reduce the number of elective surgeries funded by Medicare and Medicaid. We believe that this program can be truly effective. In a March 1983 report to the administrator of the health care financing administration, we recommended that mandatory second surgical opinion program be adopted for Medicare and Medicaid. I still stand by that position today.

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[1] See appendix p. 276.

With your permission, Mr. Chairman, I will make a copy of that report available for the record.

BACKGROUND

Like you, we have long been concerned that unnecessary surgery is wasting American lives and dollars. In January 1976, the Subcommittee on Oversight and Investigations of the House Committee on Interstate and Foreign Commerce reported that an estimated 2.4 million unnecessary surgeries had been performed in 1974 at a cost of 11,900 lives and $4 billion.

The House report concluded that second consultations could cut down significantly on unnecessary surgery. It recommended that the department:

—Promptly institute a program of independent second professional opinion to confirm an individual's need for elective surgery if it were to be funded by Medicare or Medicaid.

—Carefully evaluate that program to determine (a) its impact on quality of care, (b) its ability to contain health care costs, (c) the percentage of surgeries being performed that are unnecessary, and (d) the cost of administering such a program compared with the cost of paying for unnecessary surgery.

In response to this committee report, HHS launched a national second opinion program in 1977. It arranged for a great deal of publicity for the program and established a national hotline. Referral centers were opened to encourage people to seek, voluntarily, a second medical opinion before undergoing elective surgery and to help them locate physicians willing to provide that opinion. The main objective of the national program—which was aimed at the general population—was to decrease the amount of inappropriate surgery performed thereby avoiding the costs and risks of surgery without jeopardizing the health and well-being of patients.

As part of the overall effort Medicare not only agreed to pay its normal share of the physician charges for second opinions, but also initiated, in 1978, two demonstration projects—one in New York and one in Michigan. Their purpose was to test the concept of second opinions on Medicare beneficiaries in particular and to determine whether the financial incentive of waiving the Medicare copayment and deductible amounts would induce beneficiaries to voluntarily seek second opinions.

HCFA also encouraged States to pay for second opinions under Medicaid. As a result, State medicaid agencies agreed to include second opinions as a covered service. Seven States went further. At the time of our review, Massachusetts, Michigan, Wisconsin, New Jersey, Washington, Connecticut, and Missouri had mandatory second surgical opinion programs in operation. Under these programs, recipients were required to obtain second opinions for selected surgical procedures as a condition of Medicaid coverage. The procedures were chosen on the basis of volume, cost, and expected rate(s) of nonconfirmation (i.e., cases in which the consulting physician did not agree that surgery was necessary.)

Under each of these mandatory programs, the decision to have or not have the elective surgery still rested with the Medicaid recipient. A dissenting second opinion had no effect on coverage if the recipient chose to have the surgery performed.

OIG REVIEW OF SECOND SURGICAL OPINION PROGRAMS

In late 1983, our office began a review of second surgical opinion programs to see what affect they were having on the numbers of elective surgeries in Medicare and Medicaid. We wanted to know whether or not such programs worked and if so, what type worked best.

Based on our analysis of data available at that time, we concluded that Medicare's voluntary second surgical opinion programs were not having the desired affect, but that Medicaid's mandatory programs were reducing the number of elective surgeries.

VOLUNTARY PROGRAMS

The basic reason why the voluntary programs were not effective is simply that people will not voluntarily seek a second opinion prior to elective surgery. Nowhere is this fact more evident than in the two medicare demonstration projects funded by HHS.

For example, under the New York project, only 1,763 beneficiaries (or 1.2 percent of the 142,000 who received surgery in that year) voluntarily sought second opinions. The rate was even lower—0.3 percent—in the Michigan project where only 116 second opinions were obtained for about 44,000 surgeries. These extremely low use rates become even more discouraging when you consider that under both projects, second opinions were available at no cost to beneficiaries.

HHS reported to the Congress that waiving cost-sharing as an incentive for Medicare beneficiaries to voluntarily obtain second opinions did not appear to result in extensive use of second opinions. It further concluded that "the most striking fact regarding all voluntary programs is that few people choose to use them." It is important to note here that HHS was not restricting this conclusion to only the two Medicare demonstration projects. The evidence is clear for all voluntary programs—less than 5 percent of potential recipients take advantage of them.

Naturally, if so few people voluntarily choose to seek a second opinion, the potential for reducing elective surgeries through this means is correspondingly limited. Based on its preliminary analysis of the two Medicare demonstration projects, HHS estimated that voluntary programs reduced overall surgery rates by only two-tenths to three-tenths of 1 percent.

MANDATORY PROGRAMS

As mentioned earlier, seven States had implemented mandatory second surgical opinion programs at the time of our review. Three of these States had sufficient experience with the programs to be able to reach conclusions about their value in reducing elective surgery. We would like to share with you some of the results of these programs.

Michigan

The Michigan program started on January 1, 1980. A preliminary study made by the Michigan Department of Social Services found that surgical utilization dropped about 35 percent for the seven procedures included in the mandatory program. The annual savings attributable to the program were estimated at $3.7 million.

Wisconsin

The Wisconsin Department of Health and Social Services, in a report to its State legislature, estimated that overall surgery dropped by 33 percent as a result of its mandatory program. The program covered 10 procedures. It concluded that $22 was saved for every $1 spent on the program, for an annual savings of $2.8 million.

Massachusetts

The Massachusetts mandatory program was required by the State legislature in 1977. The program underwent two reviews by independent researchers.

The first study, published in January 1982, concluded that the program caused a 20-percent reduction in the volume of those surgical procedures covered by the program and that it saved Medicaid $3 to $4 for every $1 spent to administer it. The second independent study was performed by ABT Associates, Inc., Cambridge, MA.

The report, dated November 1982, concluded that the mandatory program: "Results in statistically significant decreases in the surgery rate for the eight program procedures taken together—the decrease ranging between about 15 and 30 percent across five geographic areas. The net savings due to the program is estimated to be about $1 million annually."

The study also stated that while it was not yet known how mandatory programs effect patients' health, it was reasonable to hypothesize that additional information provided by second opinion would, on average, enable patients to make better decisions about undergoing surgery and thereby result in improved health outcomes.

Our review of various studies done on this topic illustrated rather clearly that the reduction in the rate of elective surgery is much greater in those mandatory programs than in Medicare's voluntary program where the estimated reduction is less than one-half of 1 percent.

A major reason for this difference is that effects of mandatory programs are enhanced by what is known as the "sentinel effect." This is a phenomenon whereby physicians initially recommend fewer surgeries because they know that their decisions to operate will be reviewed by other physicians. Since most patients do not customarily seek second opinions on their own volition, the sentinel effect will not come in play to any significant degree unless the patient's option is removed—not the option to choose surgery, but the option to choose not to get a second opinion.

The National Governors Association's Center for Policy Research considered this question. It concluded that available evidence indicates that mandatory second opinion programs may be a cost effective intervention which can be implemented within State Medicaid programs.

The department was considerably less qualified in its judgment. In the March 1982 report to the Congress, HHS concluded that "sponsored studies have shown mandatory second surgical opinion programs to be cost-effective in both the public and private sectors."

Two years ago, we were convinced that second opinions were good for patients. It provided them with the confirmed information they needed to make intelligent decisions about elective surgery, and with more confidence and peace of mind about those decisions. To the extent that some beneficiaries decided against unnecessary or marginally necessary surgery because of the second opinion, they benefited in other ways we can't measure, but which flow logically from those decisions: e.g., no anxiety about or pain resulting from the surgery; and no exposure to the danger to life itself often posed by surgery and related anesthesia. Finally, such decisions were good for the program because they made more funds available for the needs of others.

Available data at that time showed that mandatory Medicaid second opinion programs were feasible and could result in significant savings. We estimated $60 million per year could be saved if all the States were required to implement mandatory programs. Similar data were not available for Medicare. But by extrapolating from the HHS report to the Congress and other data, we estimated that such a program for Medicare could save about $90 million per year—depending on the surgical procedures included. We therefore recommended in March 1983 that HCFA take the steps necessary to require mandatory second opinions in both the Medicare and Medicaid Programs.

HCFA disagreed, citing a need for further analysis and study.

WHAT HAS HAPPENED SINCE

That was about 2 years ago. Medicare, as you know, continues to operate without a mandatory program and its use in Medicaid has increased only slightly. Only four States—Tennessee, Oregon, Virginia, and Minnesota—have added mandatory programs since our report was issued.

Our conviction that mandatory second surgical opinion programs are needed to reduce the rate of elective surgery is strenthened by the growing momentum for these programs in the private sector. According to the Blue Cross and Blue Shield Association, mandatory programs have grown tremendously in the coverage provided by their member plans. In 1982, only 10 plans included mandatory programs. In 1983, there were 40. Today, about 60 insurance plans administered by Blue Cross and Blue Shield member plans require second opinions prior to elective surgery. This encompasses about two-thirds of all Blue Cross plans.

As for the need for additional analysis and study, I believe this matter has already been studied enough to arrive at a conclusion. Mr. Chairman, our charts list only some of the studies and reports that have been made on this subject. Their findings are very consistent on at least two central points: Program participants do not obtain second opinions under voluntary programs; and mandatory programs are cost effective.

We would like to comment further on the last two studies listed on the charts, because they were published subsequent to our report. Both of them demonstrate the effectiveness of mandatory second opinion programs.

Study No. 9, entitled "Study on Mandatory Second Opinion for Elective Surgery," was published in November 1984 and is an extension of an earlier study on the Cornell-New York Hospital Second Surgical Opinion Program. The results of the earlier study were published by HCFA in March 1981 (chart item No. 1). The purpose of the later study was to calculate benefit-cost ratios by major diagnoses—something that was not done in the first project. The researchers studied 6 years of data on 11 selected procedures. They concluded that, for each of the 11 procedures, benefits exceeded costs. In total, the mandatory program resulted in savings of $5.63 for every $1 spent.

The 10th study entitled "Second Surgical Opinion Programs: Public Policy Alternatives" is a draft report recently prepared by ABT Associates, Inc., Cambridge, MA, under a HCFA contract. The study examines four second opinion programs which were included in my previous discussion—the New York and Michigan Medicare demonstration projects, the National Second Surgical Opinion Program and the Massachusetts Medicaid Program. The study confirms what was previously reported in that:

—Overall, no more than 2 percent of the Medicare beneficiaries recommended for elective surgery obtained second opinions under the demonstration projects.
—Overall, there is practically no reduction in the rate of elective surgery attributed to the demonstration projects—only 0.04 percent.
—It seems unlikely that a significant sentinel effect exists for the demonstration projects since utilization is extremely low.
—The mandatory medicaid program in Massachusetts resulted in substantial reductions in surgery rates ranging from 9 percent to 30 percent.
—The mandatory Medicaid Program in Massachusetts resulted in substantial savings estimated at over $1 million annually with a savings-to-program expenditure ratio of 4.33 to 1.

The study does provide some new information on the direct effect of mandatory programs on health outcomes. This effect results from program participants making different decisions about surgery than they would have made had they not gotten a second medical opinion. The study concluded that the direct effect is "insignificant both statistically and in absolute magnitude."

Thus, mandatory programs do not adversely effect the health of program participants.

The report does not address the sentinel effect on health outcomes which results from patients not being recommended for surgery. We discussed this issue with the study's project director, who stated that there was a "good chance" that the indirect effect would also prove to be insignificant since there was no information which suggested otherwise.

The study concludes that the results can be reasonably applied to both Medicare and Medicaid. Findings concerning nonconfirmation rates and participant surgery decisions for second opinion programs are generally quite similar even across greatly differing populations.

Mr. Chairman, we believe that these studies support our position that mandatory second surgical opinion programs could reduce the number of elective surgeries in Medicaid, and therefore, in Medicare resulting in considerable savings for these programs.

This concludes my testimony, Mr. Chairman. I will be happy to answer any questions you may have.

Major Studies on Second Surgical Opinion Programs

1. 3/81 — HCFA — Analysis of Eight Years Experience of One Program
2. 9/81 — ABT ASSOCIATES — On Mandatory and Voluntary Alternatives
3. 11/81 — MICHIGAN — On Its Mandatory Program
4. 12/81 — WISCONSIN — On Its Medicaid SSOP Program
5. 1/82 — MARTIN, SHWARTZ, *ET. AL.* — Impact of Mandatory Program on Medicaid Surgery
6. 3/82 — HHS — Medicare Voluntary Programs — Effect of Waiving Cost Sharing
7. 11/82 — POGGIO AND GOLDBERG — Mass. Mandatory Program
8. 11/82 — CENTER FOR POLICY RESEARCH, NAT'L GOVERNORS' ASSN. — Controlling Medicaid Costs: SSOPs
9. 11/84 — McCARTHY, KERSHAW & RUCHLIN — Mandatory Second Opinion for Elective Surgery
10. 12/84 — ABT ASSOCIATES — SSOPs: Public Policy Alternatives

Capsule of Findings: Major Studies on Second Surgical Opinion Programs

	Study Number									
	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.
Mandatory Programs:										
Cost Effective?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Annual Savings (Millions)		$1	$3.7	$2.8			$1		Large	Large
Saving per $ Spent	$2.63+				$3 to $4				$5.63	
Surgery Reduced by		15% to 30%	35% to 40%	33(+)%	20%		15% to 30%			Large
Non-Confirm Reduces Choice of Surgery	Yes							Yes		
Direct Effect on Health Outcomes										None
Voluntary Programs:										
Use 2nd Opinions		Few				Few		Few		Few
Surgery Reduced by										(−)½%

Chairman HEINZ. I have a few very brief questions for the panel.

First, I would like to ask Mr. Harberger and Mr. Sheehan. Since having added a mandatory second opinion to your employee group health insurance plans, have there been any complaints to speak of from either physicians or health care providers in your area? Mr. Sheehan and then Mr. Harberger.

Mr. HARBERGER. No.

Mr. SHEEHAN. I do not know of any.

Chairman HEINZ. Mr. Harberger.

Mr. HARBERGER. No.

Chairman HEINZ. And the beneficiaries of your plan like that, is that correct?

Mr. HARBERGER. Yes.

Chairman HEINZ. Mrs. Ostrander, I understand that you, as you pointed out in your statement, that your organization has a mandatory second surgical opinion component for its employees' health benefits policy. What considerations motivated your organization to that second opinion?

Mrs. OSTRANDER. Well, as I said, we were no different than any other business. I am sure my two panelists to the left of me would substantiate that costs were increasing in their companies. Therefore, it was necessary to take a look at some of these areas; and that was the very same reason we determined that it was best to go to a Second Opinion Program for some high-frequency procedures and high-cost procedures. Since we only implemented it in January of this year, we still do not have adequate data; but we believe that what other companies are seeing as the result will probably be the same end result that we will have with it.

Chairman HEINZ. Thank you very much, Vita.

Mr. Inspector General, in a few minutes we are going to hear from the Health Care Financing Administration, which, I suppose, speaks for the Department of Health and Human Services; and, in effect, even though she is not here, speaks for the Secretary, inasmuch as what HCFA will say is an administration position.

Notwithstanding all the studies that HCFA has bought and paid for; notwithstanding all the studies that HHS have bought and paid for; notwithstanding all the other studies done in all the States; notwithstanding the fact that 10 States have mandatory second-opinions in for Medicaid; notwithstanding the fact that we have between 20 and 30 million health care beneficiaries not covered by Medicare in mandatory second opinion plans, such as those described by Mr. Sheehan and Mr. Harberger; the prepared testimony of the administration is in opposition to a targeted, selected second opinion for surgical procedures.

I understand that the reason that the administration gives is that there is no need for a mandatory second opinion program in Medicare because PRO's will adequately control unnecessary surgery. What is your opinion of this stand?

Mr. KUSSEROW. First, Mr. Chairman, I would point out that this is a Health Care Financing Administration position. The matter has not gone to Secretary Heckler. The reason for that, there has been division in the Department on this, and much of it has related——

Chairman HEINZ. Would you move your microphone in and down a little bit?

Mr. KUSSEROW. Much of the difference of opinion has revolved around the implementation of a prospective payment program. This has caused the Health Care Financing Administration to hold off forwarding any proposal for a second opinion program to the Secretary until a better understanding of PPS and its implications.

It is my position that the introduction of prospective payment has not diminished the need for a second surgical opinion. The prevailing notion is that the peer review organizations, which will be involved in utilization review, would fulfill the need for a second opinion. I do not agree with that, for several reasons.

First of all, the peer review organizations would be reviewing only the factual data which is on paper. Their review would be more like a consultation than a second opinion, because they would not see the patient. A second opinion is based upon actually meeting with and examining the patient.

The second reason why I think that the PRO's will not diminish the need for mandatory second surgical opinion is that more and more operations are taking place outside the hospital in an outpatient setting. Outpatient surgery is not covered by the peer review organizations and, therefore, they would not be reviewed.

Third is that the PRO review contracts call for the review of selected surgical procedures that vary from area to area and time to time. So they are not screening a uniform minimal set of surgical procedures. So, I do not believe that PPS and the PRO's diminish the need for mandatory second surgical opinions.

Chairman HEINZ. Very well.

Senator Grassley, you came in, I know you have had a very busy schedule, I can see it in front of me, and I have given other members of the committee a chance to speak as they have come in.

Senator GRASSLEY. I do not want to go through an opening statement I have, but I would like to put that in the record, and I would also have just one little point in some extent, a question that I would like to ask of Mr. Kusserow.

Chairman HEINZ. Without objection, your statement will be placed in the record at this time.

[The statement of Senator Grassley follows:]

STATEMENT BY SENATOR CHARLES E. GRASSLEY

Mr. Chairman, I appreciate the opportunity to hear from these distinguished witnesses this morning on the subject of unnecessary elective surgery for older Americans. There has been a great deal of interest in the extent to which unnecessary surgery is performed and concern over the particular health risks associated with overutilization of surgical procedures among the elderly. Elective surgery procedures have increased by 24 percent from 1971 to 1978, and rates have risen almost twice as fast for individuals over age 65. There is also universal concern over the soaring costs of health care and the recognition that there are limited resources available to individuals, corporations, and governments.

Second surgical opinion programs have been initiated on a widening scale as a mechanism for reducing costly and risky unnecessary elective surgery. Ten States, numerous insurance companies, corporations, and recently, the Federal Government, are encouraging the use of second surgical opinion programs as a key element of utilization review. In 1977, the Department of Health and Human Services initiated a national, voluntary second opinion program which involved education of the public and a national hotline for assisting in the referral of individuals to physicians willing to render second surgical opinions. Additionally, through the health care financing administration, demonstration projects have been funded for Medicare beneficiaries in New York and Michigan.

Second surgical opinion programs are a logical way for consumers to take an active informed role in matters that traditionally have been left to health care providers and shrouded in professional mystique. It should be stressed that they are not designed to measure physician reliability nor measure differences of opinion, but rather to help the patient choose among medical alternatives. In some cases, the costs and risks of surgery can be avoided without jeopardizing the patients' well being. In many plans, the patient is not obligated to forego surgery if a second opinion conflicts with an initial recommendation for surgery. However, second consultations do serve as a mechanism for helping a patient make intelligent decisions about his or her elective surgical care.

Second surgical opinion programs have proven to be effective in saving lives as well as reducing the cost of health programs. The 8-year study conducted by the Cornell-New York Hospital, as well as other studies have indicated that up to 18 percent of patients initially recommended for surgery who were required to seek a second opinion were not confirmed for surgery. Of these, 60 percent did not have the surgery performed. There is also evidence from studies that for every dollar spent to obtain a second surgical consultation, $2.63 is saved in deferred hospital and surgeon bills, lost work days, and other costs related to surgery.

I look forward to new data that I hope will be shared by HCFA and our distinguished witnesses today which will help determine the extent to which second surgical opinion requirements can be applied to the Medicaid and Medicare programs.

Thank you, Mr. Chairman, for calling this hearing to examine how these second surgical opinion programs can contribute to lower health risks and lower Federal costs for the elderly by eliminating unnecessary surgerical procedures.

Senator GRASSLEY. The fact is that there have been considerable variations in costs and services from hospital to hospital and profession to profession and, of course, we are trying to promote here the concept of consumer responsibility to some extent, in looking at what is needed and what, if it is needed, it might cost.

Has there been any interest on the part of the Department in recommending some sort of consumer health care cost information policy, in which we would be able to have through the Department the information put out of what procedures cost in various regions of the country, and what maybe specific practitioners might cost?

Mr. KUSSEROW. There has been a major effort by the Health Care Financing Administration to educate the beneficiaries of our programs, not only as to the cost of the health care, but also to make them wiser purchasers of medical services, and to encourage them to make good decisions as consumers of medical services.

Unfortunately, and this again comes from our own inspections and management reviews that deal with the beneficiaries of our program, particularly the elderly, is that, as people get older, they seem to become more intimidated by the various bureaucratic processes. They need to speak to somebody in person to communicate to them their concerns. If you leave it up to beneficiaries to try to make decisions based upon what is given to them, either in the form of literature or in some other form of impersonal advertisement, many will be less likely to make wise decisions.

That is one of the things that our study has shown, is that, with all of the encouragement, with all of the advertising about the benefits of a second surgical opinion, less than 2 percent of our beneficiaries actually would request a second surgical opinion.

Then, there have been a number of reasons given today as to why that is so, not the least of which is the fact that elderly patients fear that somehow their physicians would be offended if they learned that there would be a second opinion asked for. But, if there was a mandatory program, then, of course, that fear would be eliminated because it would be mandated by law.

Senator GRASSLEY. Well, does it go to the extent, and is it this sophisticated, of either the information being available or the attempt to get it out of how it might vary from physician to physician within a certain area or State, or the extent to which some specific procedures might be done more often and unnecessarily so in a certain region of the country, as opposed to another region; and there is some variation in the practice of medicine; I mean, that is just a fact of life, from region to region.

Mr. KUSSEROW. There are considerable differences. The practice of medicine varies from region to region and it is influenced by the medical institutions located within those regions. It would be difficult as a department to advertize or point out the differences among certain practitioners or groups of practitioners because there might be valid reasons for those differences. For example, one region may have a large number of specialists who would have a higher degree of surgery. So, there is a danger in making generalizations about the practice of medicine without knowing all of the factors in evidence.

Nevertheless, we did point out that in the aggregate, there are differences in the rates of surgery among regions that cannot be explained by local peculiarities in practices.

I think the only way we can get at this problem without interfering with the practice of medicine directly is by using the sentinel effect mentioned earlier; going out and having the physician know that there will be a second opinion and that they should not be careless about making recommendations for surgery because they may not get a confirmation. I think that would do more toward diminishing the differences and aberrations around the country than anything else I can think of.

Senator GRASSLEY. Well then, as a bottomline, you have not recommended a consumer health care cost information policy to the Department, and they evidently do not have one and are not at this point trying to formulate one.

Mr. KUSSEROW. Not as comprehensive as you point out, but the Department has long had a policy to educate the consumers of the Department as to the costs of various types of procedures and the advisability of it, and trying to educate them.

So, there has been definitely a commitment on the part of the Department to that.

Senator GRASSLEY. OK. Thank you.

Chairman HEINZ. Senator Burdick, do you have an opening statement?

Senator BURDICK. No; I have no opening statement, but I have a question when my turn comes.

Chairman HEINZ. All right.

Senator Glenn.

Senator GLENN. Thank you, Mr. Chairman.

Mr. Kusserow, following up on that a little bit, it is my understanding that the Department of Health and Human Services says that PRO's can basically take care of the problem. You respectfully disagree with that, for all the reasons that are on the charts over here, and I agree with you.

It has been said the administration's position on not going along with more stringent rules on SSOP's is because it would be unpopular with doctors and surgeons, unpopular with the medics. Is that your opinion, or what?

Mr Kusserow. Well, I am not too sure that a lot of physicians would be terribly happy about having a mandatory second opinion, it means that somebody else would be looking over their shoulder. I don't think anybody cares for that. I do not think it is the administration's position that we are afraid to offend the physician community. I think on a number of different issues we have differed with the physician community, where the interests of the public are at stake. But definitely, I think that some practitioners might be upset by that; but at the same time, I think other practitioners might welcome it for a number of reasons, one of which is that there has been an escalation in the number of malpractice suits around the country. If we had a mandatory second opinion program, it would certainly help physicians with regard to defending what decisions they make because it would act as a professional check of their recommendation to the patient in the first place.

Senator Glenn. Now, what other reason can there be for not going ahead with this at HHS?

Mr. Kusserow. I do not know, Senator.

Senator Glenn. I do not, either. I think it is fear of offending the medical profession. This is the only reason I can see, and I do not see that as being a valid reason.

Mr. Kusserow. I think that perhaps the Health Care Financing Administration is placing a great deal of expectations that cannot be met upon the physician review organizations.

But I think it would be expecting too much from a PRO organization to be able to fill the void that would exist because of the absence of a mandatory second opinion program. They are not talking to the patient. They are not examining the patient. They are only looking at the physical evidence that is presented by the primary physician. As such, I think the closest you could characterize their position to be would be that of a consultation. It is not quite a consultation, but it is more like a consultation than a second opinion.

Chairman Heinz. When you say consultation, you mean between physicians, not between a second physician and the beneficiary?

Mr. Kusserow. If you had a physician that might want to consult with an associate and show him the paper, then that would be a consultation. I would say that a peer review organization review of the documentation is more akin to that than to a second opinion, where you actually have the patient present and examined. I just do not believe that the physician review organizations are equipped, nor should we expect that they be equipped, to be able to render the same kind of opinion as would be the case if they were actually examining a patient.

Senator Glenn. But you as inspector general for DHHS feel that we should have second opinions—put it in and it would save us money, right?

Mr. Kusserow. Yes, sir.

Senator Glenn. OK. Good. That is what I wanted to get. I do not know why the DHHS does not go along with that. I agree with you.

Why do you think we have--any of you could answer this—why do you think we have this developing into a more major problem now? Do we have more surgeons than there is business for surgeons, so we are seeing more recommendations?

Mr. HARBERGER. I think that it is part of the general growing awareness that health care costs are out of control. Then you start to look for the contributing causes.

One of the things that you quickly arrive at is the sources of unnecessary hospitalization, unnecessarily costly treatment, unnecessary treatment.

Senator GLENN. Do you think it has been ever thus and we are just discovering the problem; is that it?

Mr. HARBERGER. I think it has been ever thus, and that we are now discovering the problem. Certainly, the question that we do not have in the case of the health care system, a marketplace of the usual sort, in which informed consumers are making choices. Instead the health care market is a sort of mysterious place in which, first of all, the person that needs the care is usually not the person who is paying for most of it.

So you have lots of distortions in this marketplace and you have to intervene to make it more like an informed marketplace.

Senator GLENN. OK.

Mr. Sheehan, how come that plan that you oversee up there does not also cover coronary bypass and cataracts?

Mr. SHEEHAN. I do not know why those were not selected. Those are coming into the fore a little more recently.

May I add something to your question relative to the relationship? I think the Cornell studies would indicate that there is a direct relationship between the increasing number of surgeries in the United States and the number of surgeons. I think the situation is very comparable to what is happening with hospital beds, and it is the old Parkinson's law, you know, work expands to fill the time available, the greater the number of people in hospitals, the more beds are available, the more surgeons there are, the more surgeries are going to be performed.

I think there is that kind of relationship. As Mr. Harberger pointed out, as we got into the recession, business began to take a very sharp look at what were the causes of why the costs were escalating.

Senator GLENN. Before my time is up, let me ask one other thing: If you have a first opinion that says you do not need surgery, do you provide a second opinion if the person is still doubtful? In other words, the welfare of the patient, whether that person really needs help or not, may require a second opinion even if the first recommendation is no surgery. Do you provide a second opinion for that if the person wants to go for a second opinion?

Mr. SHEEHAN. If the person wants to do that, yes, we have built into our benefit plans an incentive for the individual. If surgery is to be performed without second surgical opinion, since the benefit plan has been changed to share costs on an 80-20 basis. If, however, the person who has been instructed by their physician to have surgery, opts for a second opinion—and only 13 or 9 of them are mandatory—if he opts for a second opinion, the cost of that is paid and then even if the surgery is required, a full 100 percent is covered. So there is an incentive for him to do it. But if he goes the first time, no, there is no surgery required. The answer to your first question is no, there is no second opinion.

Senator GLENN. OK, I know my time is up, Mr. Chairman, just one point of clarification.

You said that you estimate savings of $300,000 in your plan. On what base is that? What is the total cost of the plan, so we have an idea of the proportion?

Mr. SHEEHAN. I beg your pardon?

Senator GLENN. You say that your plan has saved about $300,000 per year.

Mr. SHEEHAN. No. I cited the statistics that were given in a magazine article at Owens-Illinois Corp., not my corporation. I do not have all the data on that.

Senator GLENN. Oh, I am sorry. I see.

Does anyone know what the base was on which that $300,000 savings was?

Mr. HARBERGER. I may have the article here. Go on with somebody else, and I will try to find it.

Senator GLENN. Fine. Good.

Chairman HEINZ. Senator Burdick.

Senator BURDICK. I have listened to this testimony with interest. There are several things that have been called to my attention.

What do you do in a case where Dr. A says operate and Dr. B says do not operate? What does the patient do?

Mr. KUSSEROW. In that case, there should be additional opinions to help the patient resolve the difference of opinion. But the patient should have the final say in deciding whether or not the surgery will take place.

Senator BURDICK. With a third opinion or a fourth opinion?

Mr. KUSSEROW. Yes, sir.

Senator BURDICK. I think there is some psychological advantage to this bill, or this position. There are a lot of people that would like to have a second opinion, but they have had a long-time relationship with their doctor and they just do not like to overrule him, and this gives them an easy out. I think it is excellent from that point of view.

And, second, I have not talked to any doctor about this, maybe you people have, but I would think that a great proportion of the doctors, with a tough situation on their hands would welcome a second opinion. Am I right about that?

Mr. KUSSEROW. Senator, I think on both scores, all the evidence that we have seen to date supports your position, yes.

Senator BURDICK. I think it is a very reasonable one. The only question I have is where you have a conflict of opinion, that presents somewhat of a problem.

The other question I have is, and I do not suppose there is any history that has been recorded, but when a person decides not to have surgery, whether or not he takes a second opinion, is there anything to indicate whether that has been the right decision over a number of years? Is that a problematical question?

Mr. KUSSEROW. Not entirely. There was earlier testimony that was provided by Dr. Graboys that supported the fact that when the decision not to have surgery is based on medical evidence, the patient is not disadvantaged and does not suffer a higher mortality rate. So I think that there is evidence available on that point.

Mr. HARBERGER. May I make a comment on that, Senator?

Senator BURDICK. Certainly.

Mr. HARBERGER. It seems to me it is a mistake for us to think that just because a second opinion disagrees with the first that the second one is right and the first one is wrong. All you have determined is that there is a degree of disagreement among professionals as to the proper therapy. You have simply given the patient more information on which to make an intelligent choice—a difficult choice but an intelligent choice. The indications are that when faced with a choice between radical treatment and less radical treatment, about 88 percent of the people will avoid the radical treatment. They may be wrong in making that choice, but they have at least had the chance to make an informed choice. We should not be arrogant about what second opinions accomplish. We are simply making people better informed and making them better able to manage their own lives with all of the information we can put at their disposal.

Mr. KUSSEROW. In addition, Mr. Chairman, the ABT study—that number 10 we have up there—ABT Associates did make the observation during their study that there was no adverse health impact as a result of having a mandatory Second Opinion Program. So you have that also as evidence that it does not have a negative effect on the beneficiary.

Senator BURDICK. Well, I think this is all right, because a patient that likes his doctor for a number of years, it is kind of embarrassing to even ask for another opinion. And I would think the doctor, himself, would look at those situations and—medical science is not exact as yet—welcome this. It looks pretty good to me.

That is all, Mr. Chairman.

Chairman HEINZ. Senator Burdick, thank you very much.

You have all been exceptional witnesses. I thank you very much for the positions that you have stated here.

I have one last question to all of you, which is this: to Mr. Kusserow, actually. Mr. Kusserow, would it be your opinion that the mandatory second opinion, as described, would save a substantial amount of money to not only the HCFA, but the Federal Government which is running, as we understand it, a modest deficit of some $225 billion? I mean, are we not talking about at least hundreds of millions of dollars here and perhaps far more than that? And, if so, why is the administration recommending cost increases on beneficiaries, when we could save hundreds of millions of dollars someplace else, namely, by cutting out unnecessary costs and unnecessarily risking people's health and lives?

Mr. KUSSEROW. Mr. Chairman, I would point out that we estimated $150 million savings just looking at nine procedures. They did not include two of the major areas which are under discussion by this committee, that being the pacemaker implantations and coronary bypass.

Chairman HEINZ. Those account for almost a quarter of all the surgery procedures done by senior citizens under Medicare, it is my understanding.

Mr. KUSSEROW. And, depending upon the number of procedures, the more procedures that you can put under a mandatory Second Surgical Opinion Program, the more money you are going to save the taxpayer. At the beginning point we saw it as a $150 million for nine elective procedures. The more procedures you have, of course, the more we believe that you would save for the taxpayer.

Chairman HEINZ. Let me just kind of turn the question on its head slightly for Vita Ostrander.

Let us assume, Vita, that, in spite of all the testimony to the contrary, we did not save any money through a mandatory second opinion, we just broke even, just broke even. Would not your membership, some 16 to 20 million senior citizens, would they not want to have access to information that they could only get through a second opinion that is now basically denied them?

Mrs. OSTRANDER. Yes; I think that you will recognize that the more we do in educating them, recognizing they have many fears, and I think the second opinion at times can help alleviate those fears.

Chairman HEINZ. So, as Senator Glenn says, this is really consumer education at the grassroots.

Senator GLENN. I can help you answer your question there, too. If you ever watched an open-heart operation, you can understand why I am going to have four or five opinions if I ever get a recommendation on that one. [Laughter.]

Chairman HEINZ. And Senator Glenn is not a bleeding heart. [Laughter.]

Senator GLENN. I was that years ago; in fact, I am a frustrated doctor at heart, Mr. Chairman. That is a little-known fact, but years ago, when we were in Houston, a good friend of mine was Mike Debakey. He used to invite me in, I would go, scrub with him and stand on a little platform behind him. I have watched him do maybe 25 or 30 open-heart cases, and so I am familiar with it. That is the reason why, when you ask whether people would prefer not to go through this, in effect, I understand the problem very, very well. No one wants to go through it.

But, on the other hand, if you have to have it or you are probably going to die, why, you want to know that, too. Then you are going to go through it. But that is quite apart from the cost factor.

Mrs. OSTRANDER. I believe the area of education that has been touched on by some of the panelists, as well as some of the Senators, we feel is one of the strong areas. We have been advocating this in our second part of our health care campaign as part of our health promotion, health education.

And, as I have gone around the country, I have had some tough questions posed to me. Our members do not understand what is involved in admission, in the preadmission screenings right now. We are having to make some tough choices about how we get that information to them, so it is up front and they can understand it. We believe this second opinion is valid, we can do the same with that. Our association will continue to assist this committee in that effort.

Chairman HEINZ. I thank you all very, very much. You have been extremely helpful to us.

Senator GLENN. Mr. Chairman, if I could just have a few words?

Chairman HEINZ. Yes, by all means.

Senator GLENN. I have to leave very shortly.

But with the testimony we have heard this morning, with the figures there, with Mr. Kusserow's testimony and everything else, and with the experience of Mr. Sheehan and the people have had—I would welcome the opportunity to work together with you. Perhaps we could jointly put in a bill on this. Because if the administration will not move on this and it can save us money and save people the travail of going through surgery when it is unnecessary, I would welcome the opportunity to put in a joint bill on this.

Chairman HEINZ. Senator Glenn, I thank you, I commend you, and I accept your kind invitation.

We have as our next witness James L. Scott, the Acting Deputy Administrator for the Health Care Financing Administration, Department of Health and Human Services.

Mr. Scott, please come forward. We are pleased to have you here today. Your prepared testimony, in its entirety, will be placed in the record.

It will be very helpful, and especially so in the interest of saving time, if you could summarize your testimony so that we may have time for questions.

Please introduce your associates and proceed.

STATEMENT OF JAMES L. SCOTT, WASHINGTON, DC, ACTING DEPUTY ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY PHILIP NATHANSON, DIRECTOR OF HEALTH STANDARDS AND QUALITY BUREAU, AND STEVEN PELOVITZ, DEPUTY DIRECTOR, OFFICE OF RESEARCH AND DEMONSTRATIONS

Mr. SCOTT. Thank you, Mr. Chairman.

As you indicated, I am James Scott, Acting Deputy Administrator of the Health Care Financing Administration. I am pleased to be here today to discuss our efforts to prevent unnecessary surgery in the Medicare and Medicaid Programs and to present the administration's position on these issues.

I am accompanied on my left by Mr. Philip Nathanson, who is the Director of our Health Standards and Quality Bureau, and by Mr. Steven Pelovitz on my right, who is our Deputy Director of our Office of Research and Demonstrations.

I want to start by reaffirming that we share the committee's belief that the quality of care provided to Medicare beneficiaries can be improved and program savings achieved by preventing unnecessary surgery.

The cornerstone of our effort to reduce unnecessary surgery for the Medicare Program is the peer review organization, the PRO's, which began this fiscal year. We believe the activities of the PRO's can be and will be very successful in achieving the goal that we all are seeking, which is the reduction of unnecessary surgery.

Let me stop and review—and I will do so very quickly because I know this morning you have gone through a lot of the history involved in these issues—our efforts to achieve the goal began in 1977, when we initiated a voluntary second opinion demonstration for Medicare beneficiaries through the Blue Cross and Blue Shield plans of Michigan and Greater New York.

Additionally, HCFA funded an evaluation of the mandatory Medicaid Second Opinion Program administered by the Massachusetts Department of Public Welfare. We found in New York that while 20 percent of beneficiaries recommended for elective surgery were obtaining second opinions on their own from physicians of their choice, only 2 percent of the beneficiaries were obtaining second opinions through the demonstrations. In regard to the Mandatory Second Opinion Program for Medicaid recipients in Massachusetts, the net direct impact of the program was a 1.7 percent reduction in the surgical rates for the covered procedures. Since the direct effect of the program was only a 1.7——

Chairman HEINZ. That was in Medicaid.

Mr. SCOTT. That was in Medicaid, that is correct, Senator.

Chairman HEINZ. Just for the record, would you say that Medicaid procedures are reimbursed on the same basis on which we do Medicare? Are they nearly as generously reimbursed?

Mr. SCOTT. Well, the Medicaid procedures, Senator, are reimbursed on a lot of different methods.

Chairman HEINZ. Yes, but from what you know about State Medicaid reimbursement for specific procedures, would you say they are below Medicare reimbursement rates or not?

Mr. SCOTT. They certainly are not above Medicare reimbursement rates.

Chairman HEINZ. That is the understatement of the year!

Mr. SCOTT. Senator, there is a point to be made, the procedures are not the same; and that point will come up again and again in our discussion. In many cases, you cannot compare Medicaid and Medicare surgery.

Chairman HEINZ. I totally agree with that.

Mr. SCOTT. Senator, the direct effect in the Massachusetts program was a 1.7 percent drop, which indicated that more than 7 percent got the total reduction, was due to the indirect, or the so-called sentinel effect of the program; that is, the mere existence of an oversight process resulted in physicians recommending less surgery.

Although the results of this Medicaid demonstration are very encouraging, our evaluator did point out that program effects may differ with different target populations, and that different results might be obtained through the Medicare population. As part of the Tax Equity and Fiscal Responsibility Act of 1982, the Congress included a——

Chairman HEINZ. Let me interrupt you with a question: In your prepared testimony, it is my understanding, the paragraph at the top of page 4 says: "Notwithstanding everything you just said, the Massachusetts program did generate an estimated annual savings of $1 million and a cost-benefit ratio of 4.3 to 1."

Mr. SCOTT. It does say that; that is correct, Senator.

Chairman HEINZ. Yes; so, notwithstanding the fact that it was a very small drop in surgery, we were saving $4.30 for every dollar of cost; is that right?

Mr. SCOTT. Absolutely. No doubt about that at all.

Chairman HEINZ. And in spite of the fact that this is Medicaid——

Mr. SCOTT. That is right.

Chairman HEINZ [continuing]. Which is reimbursed largely at a much lower rate nationally—even if you will not say so, I will—than Medicare.

Mr. SCOTT. That is right.

Chairman HEINZ. That is quite extraordinary, really. Go ahead. Sorry. Please proceed.

Mr. SCOTT. In 1982, the Congress established the peer review organizations. Senator Durenberger took the lead, I believe, though, Senator Heinz, you were one of the major cosponsors and participants in that discussion.

This applied for Medicare as well as for Medicaid programs. We believe that the PRO Program already underway will result in less unnecessary surgery and increase quality of care.

Now, I want to take a few minutes to describe in some detail why we believe this is a very valid approach to this problem. Each PRO has quality and admission objectives to reduce unnecessary surgery or other invasive procedures. From the list of the 10 most frequent and 10 highest cost procedures, each PRO has chosen those procedures based upon an analysis of the data from its area on which it is to focus its review efforts. All PRO's must review every permanent cardiac pacemaker implantation procedure, in addition to determining its necessity.

Chairman HEINZ. Is that before or after the fact?

Mr. SCOTT. The pacemaker review is retrospective. Much of the other——

Chairman HEINZ. After; after it has already been done?

Mr. SCOTT. That is correct, Senator.

Chairman HEINZ. I just wanted to be clear on that.

Mr. SCOTT. Much of the other review is done on a preadmission review basis.

Chairman HEINZ. I beg your pardon?

Mr. SCOTT. Much of the review done on the other procedures is done on a preadmission review basis.

Chairman HEINZ. When you say much; on average, what would much be, 1 in 10?

Mr. NATHANSON. Preadmission reviews vary anywhere from maybe 14 percent to 100 percent of elective surgery. It varies dramatically with the PRO.

Mr. SCOTT. PRO's have a tremendous amount of flexibility, and four PRO's, I believe, have selected for surgical procedures 100 percent preadmission review.

Chairman HEINZ. So we understand what we are talking about, that is where, if you will, a patient's chart is taken to another physician in the hospital, a peer of the doctor, and shown to the doctor by the other doctor, I guess, says, "Here is what I plan to do," you know. Thank you very much. There is no contact with the patient by the peer reviewer, is there?

Mr. SCOTT. The peer reviewer does not see the patient, that is correct, Senator.

Chairman HEINZ. So the patient does not get any additional information.

Mr. SCOTT. That is correct. Let me just——

Chairman HEINZ. Perhaps the doctor does.

Mr. SCOTT. He certainly does.

Chairman HEINZ. That is very good, it is very helpful. We need to be clear on what PRO's do and do not do for the hearing. Thank you. I am sorry to have interrupted you, but I wanted to make that clear.

Mr. SCOTT. That is fine, no problem at all with being clear.

The PRO's are using a variety of methods to achieve their objectives. These include: the notification of physicians and hospitals of the procedures under review, under preadmission review, retrospective review, and denial of payment if some medical standards are not met. These methods should produce not only a direct effect on surgical rates, but a strong sentinel effect as well.

The knowledge that PRO's will be reviewing some procedures retroactively and denying payment where necessary should induce hospitals and physicians to be extra cautious in the process of recommending surgery.

We believe this oversight process will provide the same kind of sentinel effect that was observed in the ABT study.

Under Medicaid, States influence the performance of surgical procedures through a mix of approaches. As of March 1984, 21 States had prior authorization requirements for specified or all elective or nonemergency surgical procedures. Seven States had operational mandatory Second Opinion Programs, with an additional five in the process of implementation.

All States will pay for the second opinions.

Nearly half of the States have contracted with their area peer review organization for review services.

In addition, we have several other activities underway aimed at furthering the goal of reducing unnecessary surgery.

Since 1979, our public affairs office has been actively promoting second opinions.

Under Medicare, second and third opinions, or as many as required, have been covered services since 1977. In addition, Medicare has always covered consultation when it is a professional service furnished to a beneficiary by a second physician or consultant, at the request of the primary physician. Some of these consultations are undoubtedly second opinions.

The conclusion of this brief summary of my testimony, Mr. Chairman, given efforts already in place to reduce unnecessary surgery in the Medicare and Medicaid Programs, the administration does not support requiring a national mandatory Second Opinion Program at this time.

In the Medicare Program, we believe that the work of the PRO's is an excellent response to the problem. The PRO's afford HCFA the opportunity to address the particular procedures which are a problem in each area. We believe that this review will result in a direct reduction in the unnecessary procedures, as well as the reduction in surgical rates due to the sentinel effect that occurred in the Medicaid demonstration.

Mr. Chairman, that concludes the very brief summary of my remarks. Mr. Nathanson, Mr. Pelovitz and I will be more than pleased to answer any questions you or Senator Burdick have.

[The prepared statement of Mr. Scott follows:]

Prepared Statement of James L. Scott, Acting Deputy Administrator, Health Care Financing Administration

Mr. Chairman, I am James Scott, Acting Deputy Administrator of the Health Care Financing Administration (HCFA). I am pleased to be here today to discuss efforts to prevent unnecessary surgery in the Medicare and Medicaid programs. I am accompanied by Mr. Philip Nathanson, Director of the Health Standards and Quality Bureau and by Mr. Steven Pelovitz, Deputy Director of our Office of Research and Demonstrations. We share the Committee's belief that quality of care can be improved and program savings achieved by preventing unnecessary surgery.

The cornerstone of our effort to reduce unnecessary surgery for Medicare is the Peer Review Organization (PRO) program which began this fiscal year. We believe this program can be very successful in achieving the same goal we are all seeking—the reduction of unnecessary surgery.

RESEARCH EFFORTS

Our efforts to achieve this goal began in 1977, when we initiated a voluntary second opinion demonstration for Medicare beneficiaries through the Blue Cross and Blue Shield plans of Michigan and Greater New York. Under these projects the coinsurance for second opinions was waived if it was obtained from a panel of consultants composed of board-certified surgeons. The demonstration was designed to test whether the financial incentive of the waived coinsurance would increase the use of second opinions.

Additionally, HCFA funded an evaluation of a mandatory Medicaid second opinion program administered by the Massachusetts Department of Public Welfare. This program was focused on eight specified elective procedures.

Since it was a mandatory program, reimbursement was denied if no second opinion was sought. If there was a nonconfirming second opinion, the recipient had to obtain a third opinion in order for surgery to be covered by Medicaid. However, even after obtaining two non-confirming opinions, the recipient was still free to go ahead with the surgery.

Thus, the mandatory nature of the program was not that reimbursement was contingent upon a confirming opinion, but that the recipient receive a second and possibly a third opinion, before the costs of a surgical procedure would be covered.

The results of our evaluation of the voluntary Medicare program in New York were very different from those of the mandatory program under Medicaid in Massachusetts.

We found in New York that while 20 percent of beneficiaries recommended for elective surgery were obtaining second opinions on their own from physicians of their choice, only two percent of beneficiaries were obtaining second opinions through the demonstration. This two percent response had a marginal impact on surgical rates. Given the substantial costs of advertising the program, the overall evaluation of the effort was that it was not cost effective.

Two percent of beneficiaries were obtaining second opinions through the demonstration. This two percent response had a marginal impact on surgical rates. Given the substantial costs of advertising the program, the overall evaluation of the effort was that it was not cost effective.

In regard to the mandatory second opinion program for Medicaid recipients in Massachusetts, 3 percent of the participants chose not to have surgery after receiving nonconfirming second opinions. However, 1.3 percent of participants, who would not have elected surgery, decided to have surgery as a result of the program. Thus, the net direct impact of the program was a 1.7 percent reduction in surgical rates for the covered procedures.

But the most intriguing part of the evaluation was that an analysis of surgical rates before and during the program showed a 23.8 percent reduction in surgical rates for covered procedures. Since the direct effect of the program was only a 1.7 percent drop, more than ninety percent of the reduction was due to the indirect, or the so-called "sentinel", effect of the program. That is, the mere existence of the program resulted in physicians recommending less surgery.

Balancing both direct and indirect effects against program costs, the Massachusetts program generated an estimated annual savings of $1 million and a cost benefit ratio of 1 to 4.3.

REDUCING UNNECESSARY SURGERY UNDER MEDICARE AND MEDICAID

Although the results of this Medicaid demonstration are very encouraging, our evaluator did point out that program effects may differ with different target populations and that different results might be obtained for the Medicare population.

In addition, the method of hospital payment under Medicare is now dramatically different from that in effect during the study. As part of the Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248), Congress included a requirement for the establishment of Peer Review Organizations. For Medicare, as well as for many Medicaid programs, we believe that this PRO program already underway will result in less unnecessary surgery and increased quality of care.

These organizations will determine whether inpatient services provided to Medicare beneficiaries are medically necessary, furnished in the appropriate setting, and are of a quality which meets professional standards.

Each PRO has quality and admission objectives to reduce unnecessary surgery or other invasive procedures. From a list of the ten most frequent and ten highest-cost procedures, each PRO has chosen procedures, based on an analysis of data from its area, on which to focus its review efforts. All PROs must review every permanent cardiac pacemaker implantation procedure to determine its necessity.

In addition to focusing on selected overutilized procedures across their jurisdiction, the PRO's have separate objectives which focus review on specific practitioners or specific hospitals whose treatment patterns deviate from those of their peers.

The PRO's are using a variety of methods to achieve their objectives. These include: notification of physicians and hospitals of the procedures under review; preadmission review, retrospective review and denial of payment if medical standards are not met. These methods should produce not only a direct effect on surgical rates, but a strong sentinel effect as well. The knowledge that PRO's will be reviewing some procedures retroactively and denying payment where necessary should induce physicians to be extra cautious in recommending surgery.

For example, the PRO here in the District of Columbia is focusing on four procedures: gall bladder procedures, hysterectomies, coronary artery bypasses and other cataract procedures. Admission for these procedures requires pre-admission review of the necessity of the procedure. Prior consultation is used to ensure that a second physician has concurred with the need for surgery. A retrospective review validates information provided prior to surgery. Should an admission occur in which prior consultation was not sought and the admission is deemed retrospectively to be unnecessary, payment is denied.

Under Medicaid, States influence the performance of surgical procedures through a mix of approaches. The major programs are prior authorization requirements second opinion programs, and PROs. The prior authorization requirements are more restrictive than mandatory second opinion programs since the physicians employed by or acting as consultants to the Medicaid Agency can make binding decisions about whether the program will reimburse for a surgical procedure.

—As of March 1984, 21 States had prior authorization requirements for specified or all elective or non-emergency surgical procedures.

—7 States have operational mandatory second opinion programs, with an additional 5 in the process of implementation.

—All States will pay for the second opinions.

—Nearly half the States have contracted with their area PRO for review services.

OTHER EFFORTS

We have several other activities underway aimed at furthering our goal to reduce unnecessary surgery.

Since 1979, our Public Affairs office has been actively promoting second opinions. We distributed more than 9 million copies of a brochure describing the merits of second opinions. We have received an average of 50 letters a day requesting information, while our hotline averaged 1,000 inquiries per month. Finally, we have provided information on second opinions to 10 major magazines and have produced spots for talk shows and public service announcements.

Under Medicare, second and third opinions have been a covered service since 1977. In addition, Medicare has always covered consultation when it is a professional service furnished to a beneficiary by a second physician or consultant, at the request of the primary physician. Some of these consultations are undoubtedly second opinions.

CONCLUSION

Given efforts already in place to reduce unnecessary surgery in the Medicare and Medicaid programs, HCFA does not support a national mandatory second opinion program or demonstration.

In the Medicare program, we believe that the work of the PROs is an excellent response to the problem. Instead of a rigid, national program, the PROs afford HCFA the opportunity to address the particular procedures which are a problem in each area. We believe that this review will result in a direct reduction in unnecessary procedures as well as the reduction in surgical rates due to the sentinel effect that occurred in the Medicaid demonstration. Our other efforts will heighten this effect.

In regard to Medicaid, I have already noted that 21 States have programs in place that are more restrictive than mandatory second opinion programs. Rather than requiring that all States adopt mandatory second opinion programs, we prefer to continue to allow States the flexibility to address the problem in the manner that they believe is most appropriate to their situation—second surgical opinions, prior authorization or PROs.

Like you we are committed to protecting the health and welfare of those who might undergo unnecessary and life-threatening surgery. I believe that the programs the Department has underway will provide that protection.

Thank you for the opportunity to testify. I will be pleased to answer any of your questions.

Chairman HEINZ. Mr. Scott, thank you very much.

First of all, I do not want you to think, in any of the comments I make, that I am in any way being critical of Congress setting up PRO's. The peer review organizations are something I support. They are a follow-on to the somewhat more controversial professional standard review organizations which have been around for a very long time. They are aimed at trying to improve quality as well as control costs, but I must tell you from some experience we have had to date with DRG's, the PRO's would appear to be getting much more on their plate than they ever bargained for. They are expected to assure quality and cut costs.

The inspector general just released a report a couple of weeks ago that suggested that PRO's to date do not seem to be sufficiently effective in policing premature discharges of patients under the DRG system. They have a big job to do. They also have been—often bids have gone to the lowest—to the contractor with the lowest price, and sometimes that contractor cannot stay in business and do all the things that, as a PRO operator, he should do.

Notwithstanding all of that, and recognizing, therefore, both the benefits and limitations of PRO's, we have heard an awful lot of testimony here today that says that no matter how you slice it, no matter how good a job DRG's are doing, the PRO's are doing, nonetheless, it is cost effective.

Your own testimony says even in the Medicaid Program in Massachusetts that is cost effective to have selected mandatory second opinions.

Yet the thrust of your testimony is we do not want them. I really do not understand how, when you have testified to the benefits of a mandatory second opinion, you can come out in opposition to it.

Mr. SCOTT. We are not having any trouble, Senator. The Massachusetts demonstration showed that they were cost effective for a Medicaid population, using certain limited procedures. Our evaluator of that demonstration told us very clearly that the results of those savings, the results of that may not be replicated in a different population such as Medicare.

Chairman HEINZ. What about all of those studies over there on the charts? You paid for most of them.

Mr. SCOTT. We paid for them and we learned a significant amount from them. The main thing that we learned, Senator, is this, and the subterm, the sentinel effect, it may have a certain bureaucratic ring to it, but I think it is a very valid point: Once physicians know that there is an oversight process in place, that will review and make a judgment on an initial determination that surgery is required, once that kind of a process exists, there is a sentinel effect and overall surgery rates decline. That was the bulk of the savings in the State of Massachusetts.

Chairman HEINZ. No one is denying that. But let us go beyond that.

Mr. SCOTT. Now, why we think that is important, when we had the opportunity to establish an oversight mechanism through the online peer review organizations, we worked very hard in the development of their scope of work to put in there the kind of requirements that would enable the PRO's and us to get to the issue of unnecessary surgery, and subject to extensive review under the PRO Program, either on a retrospective or a prospective basis the same kinds of procedures that have been identified as being amenable to intervention.

We think that, through the PRO's, through these kinds of activities, very extensive activities involving physician organizations, we are going to create, we have created the same kind of oversight mechanism and will achieve the same sentinel result.

Chairman HEINZ. Look, no one is saying the PRO's do not help. No one is saying that there is not a sentinel effect. What we are saying is we have informed testimony by members of the Reagan administration, Mr. Kusserow in particular, who was here just a few minutes ago, and he testified to the fact that if you just included a handful of surgical procedures under Medicare that you would save at least $150 million and, I do not know whether HCFA bothers to count in tens or hundreds of millions of dollars, but, to the average taxpayer, that is still a lot of money.

Now, do you disagree with Mr. Kusserow's estimate of these savings? If so, say so. But, if not, why are you sitting there recommending against mandatory second opinions?

Mr. SCOTT. If we disagreed—well, if we agreed with the inspector general, Senator, we probably would not be in the position we are in. We obviously disagree with that.

Chairman HEINZ. And you disagree with his estimate of savings?

Mr. SCOTT. That is correct.

Chairman HEINZ. Have you got a rebuttal to his estimate of savings?

Mr. SCOTT. His estimate, to the best of my understanding, his estimates of savings are based upon experiences prior to the implementation of the PRO's and are done without taking into account the estimation of the reduction of 800,000 admissions by PRO's.

Chairman HEINZ. That is all very well, but have you—have you gone through his estimates and determined what reductions might be attributed, what, if any, savings might be attributable or even surpassed by PRO's? I mean, you are giving us an opinion that PRO's would equal or exceed his savings. You are not giving us a carefully reasoned analysis of that. Is that correct or do I misunderstand?

Mr. SCOTT. Well, I hope that what I am giving you is a carefully reasoned analysis without any numbers. [Laughter.]

Chairman HEINZ. Well, you know, that may be one of the reasons we have a $225 billion budget deficit. [Laughter.]

Mr. SCOTT. If we felt, you know, this program was cost saving, we certainly would not be walking away from it, Senator. We changed the world, we changed the world when we put the PRO's into place. We have got specific objectives in each of the peer review organizations, designed to look at the problems with unnecessary surgery in their area. Those are diagnosis specific, those are sometimes physician specific, they are sometimes hospital specific. We have confidence in the PRO's. We think they are going to be successful. We have learned a great deal from the PSRO's.

Chairman HEINZ. Let me ask you a question. Do you have two agencies within HCFA, the Bureau of Quality Control and the Office of Research and Demonstrations? It is my understanding that they both are on record as favoring mandatory second opinion provisions for Medicare. Is that correct?

Mr. SCOTT. They both participated in the meetings that we had, Senator Heinz, for me to get ready for this hearing. And in all of those briefings and in all of those discussions, they have taken essentially the same position that I have.

Chairman HEINZ. Well, you are their boss, right? Are you their boss?

Mr. SCOTT. They certainly took the same position I took and I am not in the habit of mandating that.

Chairman HEINZ. Is it or is it not?

Mr. SCOTT. Mr. Pelovitz is the Deputy Director of our Office of Research and Demonstrations. Steve, do you want to respond?

Mr. PELOVITZ. Yes; Senator, I think as we look at the experience in both our demonstrations and our evaluations of existing programs, the one thing that becomes very clear is that a sentinel effect can bring about substantial savings.

Chairman HEINZ. Yes, but I would like an answer to my question, if I may. We are not denying the sentinel effect. We have said, fine, it works, it is there, it is good. We do not need to talk about it any more. You know, we cannot quantify it. We do not have any numbers. But that does not mean it is not real.

But what I am asking is a question of fact. Is it or is it not true that in 1983, when DRG's were being legislated by the Congress, the Office of Research and Demonstrations recommended a mandatory second opinion provision? True or false?

Mr. PELOVITZ. To the best of my knowledge, we did not recommend the implementation of a mandatory second surgical opinion.

Chairman HEINZ. Were you the Director of that office in 1983?

Mr. PELOVITZ. I am the Deputy Director now, and I have been in that Office of Research and Demonstrations for——

Chairman HEINZ. When you say to the best of your recollection, is it or is it not true that you signed a memo dated May 5, 1983, that advocated a mandatory second opinion—to the best of your recollection?

Mr. PELOVITZ. To the best—I do not recall that memo, sir.

Chairman HEINZ. Would you like to see a copy of the memorandum with your signature on it? [Laughter.]

Mr. PELOVITZ. That would be fine. I mean, I do not have that in front of me.

Chairman HEINZ. Yes, it would be, if you would find it for yourself and then come back to the committee.

Mr. PELOVITZ. All right.

Chairman HEINZ. Let me say that I do not think this is any way for an agency that is paid for by the taxpayers to behave, Mr. Scott. Basically, we have had a little selective memory failure by the person sitting to your right. Now, we all have busy schedules. We all have a job to do and, frankly, selective memory failure—to be kind, to call it selective memory failure—does not help us do our jobs.

Mr. SCOTT. Senator, I have worked with Mr. Pelovitz for 4 years and I have found him to be a very honorable public servant.

Chairman HEINZ. Then maybe he is more loyal to you than he is honest with us.

Mr. SCOTT. The loyalty that is required in these jobs is loyalty to these programs. The programs serve 30 million Americans. We spend $100 billion——

Chairman HEINZ. Mr. Scott, let us not wave the flag to try and cover up the fact that Mr. Pelovitz signed a memo dated May 5 that he has no recollection of. All right? Let us not play games with the committee.

Mr. SCOTT. He does not recall. I think that is all that is necessary.

Chairman HEINZ. He still does not recall.

At this point I am going to yield to Senator Burdick.

Senator BURDICK. Thank you, Mr. Chairman. I just have one or two questions.

We are dealing with human beings and we are dealing with psychology here.

Mr. SCOTT. That is correct.

Senator BURDICK. I am going to ask a question very similar to what I asked a former witness. Is it not easier for a patient to ask for a second opinion when it is required rather than when it is not required?

Mr. SCOTT. Would you say that again, Senator?

Senator BURDICK. Patient X goes in to see Dr. A, and Dr. A says "you need extensive surgery." Now, if the law does not require a second opinion, is that patient not going to be a little more hesitant about asking for one on their own right than if the law requires it? This is human psychology now.

Mr. SCOTT. I understand it is human psychology. I get myself in enough trouble just talking about the Medicare Program without offering opinions on human psychology. I think for many patients that very well might be the case. I know for others that they are always going to want to seek a second opinion before they enter into major surgery.

Let me make it perfectly clear, from the administration's standpoint, we are not here arguing against second opinion. We believe very strongly that seeking a second opinion before major surgery is good. We would encourage beneficiaries at all times to do so.

We have run a second surgical opinion hotline to help beneficiaries to secure this kind of information. You may be right, there would be some patients who would be reluctant. But I think there are many patients, I think the experience in New York with 20 percent of the patients on their own were voluntarily seeking second opinions.

Senator **Burdick**. Well, I know from my own experience, I have been seeing a doctor for 20 years, an old friend of mine, and if he tells me I have to have something else taken out, I am kind of reluctant to challenge his opinion. And so, why is it not a simple solution to require a mandatory opinion? Why is it not that simple, make it easier for everybody?

Mr. **Scott**. We have in place a program that offers the beneficiaries an option for voluntary second opinions. We have in place a very comprehensive program of quality review, since through the peer review organization, we will address the issue of unnecessary surgery, which is what the concern is. The concern is not whether you get or do not get a second opinion; the concern is what are the best ways to reduce the incidence of unnecessary surgery?

We think that program is sufficient to meet the needs that we have. The requirement for a mandatory second opinion seems to us would be a requirement in addition to something that we believe will be successful. It is a requirement that, although some beneficiaries would like it, others might very well find it to be an inconvenience. It is not that we are arguing against initiatives to stop unnecessary surgery; we are very much in favor of those initiatives. We think that the approach that we have taken is simply one that will achieve the same goal.

Senator **Burdick**. Do you mean to say that you can achieve the same goal by a voluntary requirement?

Mr. **Scott**. No; Senator, what I said is because of the combination of the voluntary activities that take place, plus the very extensive medical review activities that take place in the peer review organizations, it is our judgment that those results would be equal to or greater than a mandatory second surgical opinion.

Now, after we have some experience with the PRO's, this is one of the areas that we are going to take a very careful look at, and if we are not achieving the kind of results——

Senator **Burdick**. Let us look at the doctor now. Is it not going to be more palatable for him to have another doctor look at it by law rather than by consent? Would that not be easier for him?

Mr. **Scott**. There again, I certainly would not want to offer an opinion as to how the organized medicine in general or how individual physicians, Senator, would react. I am sure that there would be some who would, in fact, welcome that. I am sure that there would be others who might be offended. It is just hard to predict. That is going to depend upon the physician and the relationship that the patients have had with those physicians.

Senator **Burdick**. Well, I think it is just common sense that a doctor is required by law to do it, rather than have the patient ask for it. It is much easier for him and the patient, both.

Mr. **Scott**. We require the doctor by law to do a lot of things in our programs, Senator, and I have not noticed a great deal of enthusiasm for many of them lately.

Senator BURDICK. Well, maybe I have been around people too long; I just know how they act. Thank you.

Chairman HEINZ. Senator Burdick, thank you very much.

Mr. Scott, you are aware that there are several PRO's, among them one in Arizona, that require mandatory second opinions; are you aware of that?

Mr. SCOTT. I was not aware that the one in Arizona required mandatory second surgical opinions; I was aware that they were interested in that whole issue, and looking at it.

Chairman HEINZ. I will send you some information on that.

But is it not true that there are at least three PRO's that do have mandatory second opinions?

Mr. NATHANSON. Senator, it is not true that, as part of their contract, or what we are paying for them, or what we have approved, that they have mandatory Second Opinion Programs. There have been some PRO's that have asked us if they could have mandatory Second Opinion Programs and, in each case, we asked them what it is they hoped to accomplish, what the bottom line might be, what advantage over the way they do their review now might be. In the case of Arizona, we find no advantage, to their idea of——

Chairman HEINZ. I am not surprised.

Mr. NATHANSON. But, Senator, actually we had a reason for it. Perhaps that is surprising to you, but we did have a reason for why we found that.

Chairman HEINZ. When you get all the questions from me, we will have all of that on the record.

Mr. NATHANSON. OK.

Chairman HEINZ. OK. I would like to return to, basically, the question I proposed to the last panel, and Senator Burdick really was asking the same question, too, I think, which is this:

Let us assume for the moment that you do not save any money by implementing mandatory second opinions—do not save any; you do not lose any, but you do not save any. Why would that not—even if you did not save any money and did not lose any money, would it not be a good thing to do in and of itself?

Mr. SCOTT. Well, it is good that we come back to this because this is the more important issue. We sometimes focus in this town on what the cost of something is, like the cost of unnecessary surgery. We now get a chance to talk about the impact on people. These are people to whom surgery is done. There are risks associated with that, and we clearly, every one of us in this room, are not in favor of unnecessary surgery. What we hope to do, what I think our public policy goal would be, is to identify those ways where we can intervene in the process and reduce the number of surgical cases that are unnecessary that are being performed.

I know you are probably tired of it. The peer review program offers us some unique opportunities to do that. I admit that there is value to the beneficiary education that comes through a Second Surgical Opinion Program, but the peer review program offers us the opportunity to interact with physicians who deal with physicians on their practice patterns. If the physician orders surgery——

Chairman HEINZ. Yes; but answer my question, if you would. Everything you say is fine. I am not quarreling with that. But my question was: If we knew for a certainty, if we knew for a certainty, that we would just break even on second opinions, well, second opinions cost money, but there would be less surgery to offset that beyond what you are now achieving with PRO's, would you favor or not favor a mandatory second opinion, knowing that people at least would be better informed?

Mr. Scott. We simply do not see any additional advantages to it. Since we do not see——

Chairman Heinz. But based on what? I mean, I have given you a question that I think is pretty clear, which is: You do not lose money, you do not save money; it is a hypothetical question. What I think you are saying is that you do not see any advantage under that hypothetical to giving the consumer, the senior citizen on Medicare, additional information with which to make a judgment.

Now, a representative of the American Association of Retired Persons, their president, Vita Ostrander, just testified that they think it would be very beneficial to their membership, 16 million senior citizens. Why do you second guess them?

Mr. Scott. Well, we—I am in the awkward position here of disagreeing with the senior citizens organizations as to what we think is in the best interests of senior citizens. We do not necessarily—I understand, that's where I am. We do not necessarily think that the mandatory second surgical opinion is going to work in the best interests of the senior citizen community.

Chairman Heinz. Even though they have a different opinion?

Mr. Scott. Where do——

Chairman Heinz. Let us suppose—why do you and they differ on that?

Mr. Scott. That is something that I am going to take the opportunity in the next couple of days to talk to those people, because I am surprised to find us in this position on this issue. A second surgical opinion mandated——

Chairman Heinz. I commend you at that. You know, I do not know how long you have been at the Health Care Financing Administration, but it would be a good idea, since most of the money you distribute is for the benefit of Medicare people, to meet some of the people who represent these people you are supposed to help. That is an excellent idea.

Mr. Scott. I know many of those people. I am surprised on this issue that we are on this side of it. We are frequently in disagreement with the organization.

To accomplish this, you have got to make a change in the statute. There are some that many I think would argue this could be conceived to be a restriction in the Medicare benefit. It will reduce the access to the Medicare benefit, in the view of some people by requiring a second surgical opinion. There is a great deal, there can be a great deal of inconvenience associated with the achieving of second surgical opinions, Senator.

I happen to be from rural Kansas. And there is a surgeon in the town of Smith Center, KS, and if you want a second opinion on his recommendation for surgery, you go 75 miles to Hays, KS. So that is a burden.

Chairman Heinz. Earlier, Mr. Scott, you would notice every time I described with particularity a notion of a mandatory second opinion, it included a waiver for, quote, "hardship", unquote, a broad term designed to take into account exactly what you have just described. So, you know, you can sit there and try to nitpick ideas together, but I urge you to think through the idea before you nitpick it.

I want to put into the record a memorandum dated May 3, 1983, signed by Mr. Pelovitz, on the subject that we discussed earlier, namely, the memo that concludes, the concluding paragraph which says, "We recommend that such a legislative initiative include a provision for program evaluation that would examine both the cost effectiveness of the program and its effects on health outcomes. We suggest that the SSOP and its evaluation run for a period of 3 years at which time a decision could be made to continue the program as is, add additional procedures, or discontinue the program.

I sent a letter to the Secretary on March 1, asking five questions. In the responses that I have received from you here today, I am really not much wiser about the last three, in particular, of the five questions.

I would request, therefore, and I will give you a copy of this letter as well as put a copy in the hearing record, that you provide to me, on behalf of the Secretary or through the Secretary, as procedures dictate, no later than March 20 written answers to those five questions.[1]

Do you think you can accommodate the committee in that regard?

Mr. Scott. Yes, sir.

Chairman Heinz. Any problems?

Mr. Scott. I do not anticipate any problem whatsoever.

[The letter referred to follows:]

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[1] See appendix p. 107.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Memorandum

Date MAY - 3 1983

From Director
Office of Research and Demonstrations

Subject Comments on Office of Inspector General Final Report—A Mandatory Second Opinion Would Prove Beneficial to the Medicare and Medicaid Program

To Director
Office of Executive Secretariat

In our response to the Office of Inspector General's (OIG) draft report, ORD indicated a willingness to assist the OIG. We are pleased to see that the results from ORD's second opinion studies were taken into account by the OIG in revising their initial cost savings estimates. While it can still be argued that these estimates remain "rough around the edges" (i.e., we have no empirical evidence on how a mandatory Medicare SSOP would work) we nonetheless concur with the OIG's general conclusion—some form of mandatory Medicare SSOP is worthy of implementation now.

We continue to agree with our earlier comments that there is good evidence that a mandatory SSOP could substantially reduce the amount of surgery performed for both Medicare and Medicaid beneficiaries resulting in substantial cost savings. We suggest that HCFA proceed with a legislative initiative as outlined by the OIG to implement a national mandatory SSOP targeted at select procedures. To accomplish this, HCFA will need to specify what procedures to include in the program and will have to carefully study the administrative procedures necessary to implement a mandatory SSOP for Medicare beneficiaries. ORD's second opinion demonstration and evaluation studies can provide guidance in both areas. Such a program would be by far the largest SSOP ever attempted. For example, the five most frequent elective surgical procedures among Medicare beneficiaries account for more than 1 million operations annually.

We recommend that such a legislative initiative include a provision for program evaluation that would examine both the cost-effectiveness of the program and its effects on health outcomes. We suggest that the SSOP and its evaluation run for a period of three years at which time a decision could be made to continue the program as is, add additional procedures, or discontinue the program.

Thank you again for the opportunity to comment on this report.

Bryan R. Luce

Chairman HEINZ. I must say I remain somewhere between amazed and stunned by your testimony, but I guess even if we disagreed over the facts, and I am not saying that all these studies are right, there are just 10 of them, mostly paid for by you, but let us assume that we differ on the facts; what I cannot get over is your conclusion that were we to agree on the facts, which were that this program did not save any money at all, did not cost any money, but you still would not want to do it in order to, in a prudent and careful way, in order to better inform the beneficiaries of the program which you run, as Acting Administrator of HCFA, to better serve the people that all their lives contributed into the health insurance fund, from which you are making payments now to benefit them.

If the people who run programs have some other agenda that is unrelated to the people those programs are suppposed to benefit, it becomes deeply troubling.

Now, I honestly have to tell you, after listening to your answers, I do not know what it is that you are objecting to. Maybe it is the facts. Maybe you really sincerely believe that mandatory second opinions, as described, will not save money or will not result in less procedures and less risk to beneficiaries. Maybe you sincerely believe that. Somehow I do not think so. Somehow I think that you have just come to a conclusion that putting in DRG's, you just do not want to rock the boat; that you just, right or wrong, you are going to just go through a period of 2 or 3 or 4 years, however long it takes us to implement DRG's, and we are just going to sit there and do nothing. Now, maybe I am wrong.

Mr. SCOTT. I think you are, Senator.

Chairman HEINZ. But I have received testimony to the contrary in the Finance Committee, where my colleague, Senator Durenberger, had said on the record, "Look, the arrangement that we made, that HCFA made, with the Hospital Association, we are not going to do anything on any changes while DRG'S are going in," you know, because that was the deal. They would support our putting in DRG's in the 1983 Social Security Act amendments, if we promised—we, the administration and the Congress—not to rock the boat for 3 or 4 years. Now, you are telling me that Senator Durenberger did not know what he was talking about?

Mr. SCOTT. I certainly did not say that. I am saying, in the context that you asked that question, I gave a response. Senator, let me make some general comments. One, the issue, the primary issue is, do we——

Chairman HEINZ. But what, what is the answer to my question?

Mr. SCOTT [continuing]. Do we tolerate unnecessary surgery? We have learned a significant amount from those demonstrations. We learned very much that the success depends upon the existence of an oversight mechanism and the physician's awareness of that—the sentinel effect, I know you did not want to talk about it again—we learned that from the demonstrations.

We had a unique opportunity furnished to us by the Congress in the implementation of the PRO Program to move ahead very aggressively on quality issues. We have put into place significant quality assurance kind of mechanisms in the PRO Program that we believe will achieve the same kind of results that are being talked about with mandatory second surgical opinions. All we are disagreeing about is on——

Chairman HEINZ. When will you come to a conclusion, one way or another, that you are right?

Mr. SCOTT. We will come to that conclusion in the next 6 to 9 months. And, if we are wrong, we will be back.

Chairman HEINZ. What will be the methodology? Why is it going to be 6 to 9 months? What is happening that you are so certain you will come to a clear conclusion, totally supported by the evidence?

Mr. SCOTT. The PRO Program, like any new Federal program that is implemented is one that is going to require significant direct Federal oversight in its first and second years. We plan on being very aggressive in our oversight of the PRO programs, to make sure that it achieves the results that we want, as the information is reported in from the PRO's about their success in meeting their objectives, the elimination of 800,000 admissions or the deferral of 38,000 unnecessary invasive procedures, we will be able to measure to the PRO's success in——

Chairman HEINZ. Wait now, measure the PRO's success against certain objectives.

Mr. SCOTT. That is correct.

Chairman HEINZ. That is fine; nothing wrong with that.

But to say, having met those objectives, and then deduce from that that mandatory second opinions are unnecessary is not logical. What you need is a controlled experiment.

Now, with all the care, and you have an enormous amount of expertise, you know what controlled experiments are, You know what control groups are. You know what pairings are.

Do you have any experiments testing the additional effectiveness, on the one hand, of mandatory second opinions in combination with PRO's, and do you have any pairs of testing of simply mandatory second opinions standing alone, perhaps, without the preadmission aspects of PRO's so you can get some sense of whether or not, now, this careful experimentational, Descartian approach that you have taken is really validated or invalidated by good data?

Mr. SCOTT. None of those kinds of experiments are currently on the drawingboard.

Chairman HEINZ. Is there a good reason not to, given the facts, given all these studies that go back to 1981? You people sitting there are in charge of the demonstration, the testing and so forth, and you are telling us that you have spent tens of millions of dollars, I guess, on these studies, and the one obvious question that is going to come up, which is: Are mandatory second opinions going to save even more money than PRO's that no one ever considered over the last 4 years, structuring some kind of little controlled test operation to answer that question.

Is my understanding of your, what you have decided not to do, correct?

Mr. SCOTT. I said there are none of those on the board at this point in time. I am certainly not foreclosing that we, as we continue to develop our research agenda, will not decide to move in that direction.

Quite honestly, Senator, there are many important questions in the Medicare Program that we would like to research which we have been unable to address at different times. This is one that I am sure will continue to come up and we may very well, in the future, embark upon the type of activities you are talking about.

Chairman HEINZ. Mr. Scott, yes, and this is one of them that you have been addressing. Now, we only go back to 1981, these studies go back to 1977, and now you are saying, oh, there are a lot more important things, you know, this is a new idea.

This is not a new idea.

Mr. SCOTT. The one thing that we felt was the most valuable out of these studies, we learned from that, and that is the same kind of initiative we tried to put in place.

Chairman HEINZ. Well, can you answer one last question for me?

Mr. SCOTT. I am not having much luck so far, but I will try, sir.

Chairman HEINZ. You are sure not. Maybe we should give you a second chance. [Laughter.]

Mr. SCOTT. If I had a choice, I would like to forego that, sir. Once is quite enough. [Laughter]

Chairman HEINZ. If I had given some of your answers, I would have, too.

We had testimony from the private sector here today. They are putting in mandatory second opinions. They testified that between 15 and 20 million Americans are being covered by employer-employee health plans, which includes mainly people who are under 65, who have an incidence of surgery significantly below that of senior citizens, that they find mandatory second opinions for specific procedures to be very cost effective, along with the equivalent of PRO's, namely prescreening. They do both. They do prescreening and they do mandatory second opinions.

And what I hear you saying, which is something of an absurdity to me—pardon me if I use the word, but it is true—that what is working in the private sector, what has been proven cost effective in the private sector, what has been proven as humane in the private sector is not something that you are willing to recommend.

Mr. SCOTT. Because of the kinds of populations covered, and because there are differences in the relationships between employers and employees and the entitlement programs we administer, it comes back to the basic question that we believe what we have in place is sufficient to address the problem of unnecessary surgery.

Chairman HEINZ. Your belief is noted. The rationale for getting to your belief does not seem very strong.

Mr. SCOTT. Well, we believe that it is. We clearly disagree on that.

Chairman HEINZ. If there are no further comments, the hearing is adjourned.

[The committee was adjourned at 12:35 p.m.]

APPENDIXES

Appendix 1

[Staff Briefing Paper Prepared for March 14, 1985 Hearing

Unnecessary Surgery: Double Jeopardy for Older Americans]

March 13, 1985

Section 1. Summary of Findings

1. The surgery rate in the United States is the highest in the world and it is rising at an unprecedented rate.
   - o Four in ten persons who enter a hospital undergo surgery.
   - o Since 1971, the rate of surgical operations increased more than four times faster than the growth in the population.
2. Older Americans are being guernied into operating rooms at astonishing rates -- rates much higher than for the under 65 population.
   - o Americans over 65 are subjected to 80 percent more surgeries than those under age 65.
   - o For the 11 most common elective surgical procedures, there has been a 130% increase for aged patients since Medicare was enacted, with the largest portion of this increase occuring since 1975.
   - o Coronary artery bypass surgery on older men has increased faster than any other type of surgery, rising 1,000 percent between 1971 and 1978.
3. Nearly half of all Medicare expenditures are for surgery or surgery-related services.
   - o For short stay hospital visits, 48 percent of Medicare expenditures -- $16 billion -- is surgery-related.
   - o More than one-third of physician care reimbursed by Medicare, or $4.4 billion, is surgery-related.
4. Local medical convention and individual physician bias play a major role in determining whether surgery is performed. Consequently, per capita surgery rates vary widely from region to region, state to state and even between adjacent localities.
   - o Hysterectomy is performed 80% more often in the South than in the Northeastern United States, and 300% more often in one local area in Vermont than in another area in that State.
   - o In Massachusetts, the likelihood of hernia repair surgery varies by as much as 380 percent from one region of the state to another, while pacemaker surgery varied by as much as 1250% among regions.

5. Surgery is dangerous for anyone, but especially for older Americans, who face much higher risk of complications, disability and even death from surgery.

   - The likelihood of surgery-related deaths more than doubles for each decade of age after 65.

   - For prostatectomies, the surgery-related death rate jumps from 68 per 10,000 among those 65-74 to 160 per 10,000 for those 75-84 and 405 per 10,000 for those over age 85.

6. According to unpublished data provided to the Special Committee on Aging, unnecessary surgery is widespread.

   These data show that as much as:

   - 23% to 36% of cataract surgery may be unnecessary;
   - 27% to 32% of knee surgery may be unnecessary;
   - 17% to 43% of hemorrhoidectomy may be unnecessary;
   - 15% to 31% of gall bladder surgery may be unnecessary;
   - 14% to 29% of prostate surgery may be unnecessary;
   - 5% to 28% of hernia repair surgery may be unnecessary.

7. Reducing or eliminating unnecessary surgery could save billions of dollars for the Medicare and Medicaid programs.

   - Savings from reducing unnecessary surgery for just nine elective surgeries (ranging from cardiac pacemakers to hernia repair) would save from $0.7 billion to $1.2 billion each year in the Medicare program.

   - Reducing unnecessary cardiac pacemakers implants alone would save up to $358 million each year for Medicare.

8. One solution to the problem of unnecessary surgery would be a requirement that all Medicare beneficiaries seek a second opinion when surgery is recommended by their physician.

   - When second opinions are mandated, rates of surgery are reduced by as much as 45 percent, with no apparent threats to health status.

   - Ten states and hundreds of private insurance policies now require second opinions.

   - Even the quality control mechanisms established by the federal government -- the Peer Review Organizations -in some cases have implemented mandatory second opinions as a further and necessary check on unnecessary surgery.

PROJECTED SAVINGS FOR MEDICARE TRUST FUND FROM REDUCING UNNECESSARY SURGERY #

Surgical Procedure	Total Approximate* Medicare Payments ('85)	Lowest Reduction+ in Surgery Rate	Highest Reduction+ in Surgery Rate	Range of Savings* to Medicare
Cardiac Pacemaker	$1.085 billion	30%[1]	33%[1]	$325.5 to $358.1 million
Cataract Surgery	$655.8 million	23%[2]	36%[3]	$150.8 to 236.1 million
Gall Bladder Surgery	$591.3 million	15%[2]	31%[4]	$ 88.7 to 183.3 million
Prostate Surgery	$605.5 million	14%[5]	29%[2]	$ 84.8 to 175.9 million
Knee Surgery	$136.4 million	27%[6]	32%[5]	$ 36.8 to 43.7 million
Hysterectomy	$152.9 million	8%[3]	45%[4]	$ 12.2 to 68.8 million
Back Surgery	$ 92.8 million	18%[4]	36%[3]	$ 16.7 to 33.4 million
Hernia Repair	$225.1 million	5%[2]	28%[4]	$ 11.2 to 63.0 million
Hemorr-hoidectomy	$ 41.0 million	17%[2]	43%[7]	$ 7.0 to 17.6 million
Nine Surgery Totals	$ 2.5 billion*	17% avg. lowest reduction	35% avg. highest reduction	$733.7 to 1.180 billion saved for Medicare alone*

NOTES:

*Payments and Savings exclude doctors' fees, and Part A Capital and Teaching cost payments. These payments would also be reduced, particularly in the urban hospitals, with highest payments and therefore highest savings likely.

+Footnotes 1 through 7 describe the source of each estimate. Please see other side of this page.

#Volume of each surgery for aged from 1983 National Hospital Discharge Survey, adjusted to reflect fewer admissions for Medicare than total population 65+, and to reflect fewer admissions in 1984 than in 1983. Cost data per surgery based on volume weighted average of DRGs comprising each category, applying 1985 DRG prices to approximate proportion of Medicare admissions for urban and rural facilities.

FOOTNOTES:

1. Special Committee on Aging, Pacemaker hearings, September, 1982.
2. DHHS Office of Inspector General, March, 1983 Semi-Annual Report.
3. Wisconsin Medicaid second opinion program statistics.
4. New Jersey Medicaid second opinion program statistics.
5. New York State Civil Service second opinion program statistics.
6. Michigan Medicaid second opinion program statistics.
7. Connecticut Medicaid second opinion program statistics.

Section 2. Background

The first serious attempt by the Congress to identify and deal with the problem of "unnecessary" surgery in the Medicare and Medicaid programs was launched by a House Interstate and Foreign Commerce Subcommittee in mid-1975. Following a series of hearings, the subcommittee concluded that approximately 2 million unnecessary surgical procedures had been performed in 1974 at a cost of $4 billion.The subcommittee recommended that, in addition to existing PSRO utilization review, the HEW "promptly mandate second professional opinions to confirm the need for elective or non-emergency surgery under Medicare and Medicaid"(see Jan. 1976 subcommittee report).

This same House subcommittee held a follow-up series of hearings in 1977,ending with the HEW promising to heavily promote voluntary second surgical opinion programs, and, if proven ineffective, the Department would "be prepared to require second opinions for selected non-emergency" surgical procedures (see 11/1/77 testimony of HEW Under Secretary Hale Champion).

The Federal commitment to experimenting with the second surgical opinion was late in coming, as the concept at that time was well on its way to being established in group health insurance plans. The Cornell-New York Hospital Program adopted a second surgical opinion provision (SSOP) in 1972. By 1976, Blue Cross and Blue Shield programs in New York, Michigan, Pennsylvania and New Jersey were offering a voluntary SSOP to policy holders; and, in that same year, the Massachusetts Legislature provided for a mandatory SSOP in that State's Medicaid Program beginning in 1977.

The Federal experiment with, and study of, the SSOP was initiated in 1978 and consisted of the following: (1) three-year demonstration projects in New York City and Detroit metropolitan areas for Medicare patients, which utilized a voluntary SSOP and ended in 1981; (2) a voluntary National Second Surgical Opinion Program which was to "encourage" the public through media promotion to obtain second surgical opinions and offers a nationwide toll-free "hotline" information service to consumers; and (3) a five-year study by the Health Care Financing Administration (HCFA) of these Federally-funded projects, the Massachusetts Medicaid mandatory SSOP and other major SSOPs in both the private and government sectors.

Perhaps the most important finding to coming out of the two Medicare voluntary SSOP demonstrations in New York and Detroit is that the voluntary SSOP does not work (less than 3% of the beneficiaries participated) and therefore is not cost effective. The voluntary nationwide toll-free "hotline," while still in operation, has received an average of only about 1,000 calls (20 calls per State) per month.

HCFA's just-completed SSOP study (it ran seven years instead of five), however, shows that the mandatory SSOP in the Massachusetts Medicaid Program reduced elective surgery rates by as much as 30% (see draft report, p. 290) and proved to be cost effective. The HCFA study estimated that, for every dollar spent in the program, there was a net savings of $4.30 (see draft report, p. 139). More importantly, in assessing the health effects of the mandatory SSOP in the Massachusetts Medicaid program, the draft report on the HCFA study states: "In summary, the unambiguous results from the analyses on the uncomplicated cases suggest that the Massachusetts mandatory SSOP has no appreciable impact on health outcomes." (see report, p. 163)

Midway through HCFA's $2.5 million SSOP study, there began a ground swell shift in both the private and public sectors away from the voluntary SSOP to insurance plans with the mandatory provision. For example, by 1983, Medicaid programs in seven states included the mandatory SSOP (see DHHS OIG 3/22/83 report). The Blue Cross & Blue Shield Association reports that, while only 10 of its 65 plans nationwide in 1982 offered a mandatory SSOP, the number had jumped to 40 in 1983. According to the Aetna Insurance Co., the number of its employer policy holders with a mandatory SSOP soared from only 15 in mid-1983 to a current total of 3,164.

The Department of Health and Human Services Inspector General (IG) first recommended in 1982 that HCFA "seek legislative change to the Social Security Act that would require Medicare and Medicaid beneficiaries to seek a mandatory second surgical opinion for selected surgeries. The IG reiterated this recommendation in his latest report of November 1984.According to the IG report: "HCFA agreed that there is evidence that a mandatory SSOP might reduce the amount of unnecessary surgery performed. HCFA believed, however, there were many unanswered questions in this area . ."

The IG, however, after having reviewed a draft of the HCFA seven-year study of SSOPs, continues to stand by his recommendation for a mandatory SSOP in both the Medaicare and Medicaid programs. Meanwhile, HCFA has still not issued a final report on its SSOP study, a report that was originally scheduled to be published more than a year ago.

Section 3. Utilization of Elective Surgical Procedures

Trends in Surgical Utilization.

The surgery rate in the U.S.is the highest in the world. Surgical discharges account for about 40% of total hospital discharges in the U.S. Moreover, since 1971 the rate of operations performed increased more than 4 times faster than the rate of population growth, for a net increase per 100,000 population of 93% from 1971 through 1982. (Source: NCHS)

Compared to the surgery rates for the rest of the population, the elderly undergo surgery at still higher rates; in fact, individuals over 65 undergo 80% more surgery on average than the under 65 population. These high rates of surgical utilization for the elderly have increased even faster than the rapidly increasing surgical rates for the rest of the population (see Table One, below).

Table One.

CHANGES IN AGE-SPECIFIC RATES OF SURGERY 1965-1977
(Rate of Surgery per 1,000 Population)

Age	1965	1977	% Increase
Under 65yrs	74	92	24%
Over 65yrs	105	166	58%

The extremely high rate of increase in surgery performed on the elderly has been cited as evidence of overutilization of Medicare. In response, other analysts have asserted that the pronounced increase in the rate of surgery for the elderly since 1965 has been due to pent-up demand for necessary surgery, which demand was unleashed as the passage of the Medicare legislation made funding available for surgeries that had been postponed by the elderly because of scant resources. Yet, the graphs that appear as an appendix to this briefing paper provide evidence that the rates at which several surgeries are performed on the aged have increased most since 1975.

Some surgeries are predominantly performed on the elderly, so that the number of operations performed on Medicare beneficiaries represents a large proportion of of the total number of those operations performed. For example,

86% of all hip joint surgeries,

78% of all pacemaker surgeries,

75 % of all cataract surgeries,

74% of all prostatectomies,

69% of all femur fracture reduction surgeries,

57% of all total hip replacement surgeries, and

23 to 28% of all gall bladder, inguinal hernia, and coronary bypass surgeries were performed on persons 65 years of age and over (source: HCFA and Health Planning Council of Greater Boston). In addition, hospital discharges for these few procedures made up 23% of all Medicare discharges in 1980 (source: HCFA Draft Surgical Mortality Paper)

Many of the surgeries disproportionately undergone by older Americans began to be performed at dramatically higher rates during the 1970s, increasing between 1971 and 1978 to the following extent (source: National Hospital Discharge Survey, NCHS):

Coronary Artery Bypass Surgery up 275% (up 995% for men over 65);

Cataract surgery up 46.9%;

Prostatectomies up 43.5%;

Gall Bladder surgery up 15.8%;

Similar findings were reported for the State of Massachussetts by the Health Planning Council of Greater Boston, which identified large rate increases between 1980 and 1982 for the following additional surgical procedures commonly performed on the aged:

Coronary Artery Bypass Surgery, up 54%;

Cardiac Catheterization, up 34%;

Hip Replacement, up 19%;

Pacemaker Insertion, up 12%.

During this two year period, the elderly population of Massachussetts increased by less than 1%.

Hazards Associated With Elective Surgery.

Older Americans are disproportionately harmed by unnecessary surgery for two reasons: as noted above, individuals over 65 undergo 80% more surgery than those under 65 years of age; and the risk of complications, disability, and death from surgery and general anesthesia increases steadily with age. Table Two, derived from a HCFA Working Paper, shows how mortality rises with age for each of several surgical procedures commonly performed on the aged.

Table Two.

AVERAGE ANNUAL NUMBER OF DEATHS OCCURING WITHIN 1.5 MONTHS POST SURGERY
(1979-1980)

Surgical Procedure	Deaths per 10,000 Surgeries Age 65-74	 Age 75-84	 Age 85+
Prostatectomy	119	269	631
Gall Bladder	210	534	1157
Hernia Repair	58	176	447
Cataract Surgery	33	56	92
Reduction Femur	401	780	1354
Coronary Bypass	571	975	N/A
Total Hip Replacement	117	219	931
Other Hip Surgery	347	684	1270

The chart above shows, for example, that death rates more than double for individuals older than 75, compared to those aged 65 to 74, who undergo such common elective surgical procedures as gall bladder removal and hernia repair. For every one of these common procedures, surgery becomes more hazardous with each additional year of age of the patient undergoing the surgery.

. The fact that older Americans are more vulnerable to fatal injury from even routine surgery makes it particularly important for Medicare program managers to question the propriety of the huge increase in the rates of elderly persons undergoing surgery, and to take every possible step to minimize unnecessary surgery in the aged population.

In addition to the greater risk of death with increasing age, another factor affecting mortality is the relative risk involved with each particular procedure -- which can be assessed by the difference between the "expected" death rate for elderly Medicare beneficiaries and the death rate of similar persons undergoing surgery. According to the HCFA Working Paper, "excess mortality" is a figure based on the number of deaths occuring in the population undergoing surgery, "compared to the death rates that would occur if the same population experienced the death rates prevailing among the Medicare aged" population.

"Excess mortality" is not useful as a measure of actual death rates attributable to a given surgery, in part because the population undergoing surgery may well be more vulnerable to the trauma of surgery specifically because of the problem for which they are receiving surgical treatment (or related health problems) -- which would explain some portion of their higher death rate. In addition, it fails to consider what would have happened to these people if they had not obtained surgery.

Nonetheless, it is the best available estimate of the relative mortality associated with the trauma of surgery, and can be used to assess the relative riskiness of different surgeries.

Table Three shows the "excess mortality" associated with each of the surgeries discussed above.

Table Three.

EXCESS MORTALITY IN THE FIRST 1.5 MONTHS FOLLOWING SURGERY
(1979-1980)

Surgical Procedure	Excess Mortality per 10,000 Surgeries		
	Age 65-74	Age75-84	Age 85+
Prostatectomy	68	160	405
Gall Bladder	176	454	968
Hernia Repair	10	73	233
Cataract Surgery	-3	-24	-97
Femur Reduction	369	706	1172
Coronary Bypass	527	881	N/A
Total Hip Replacement	82	141	748
Other Hip Surgery	315	609	1087

The chart above is based on Medicare data, including deaths occuring outside the hospital up to one and one-half months post surgery. In their draft report, HCFA notes that many studies have found much lower rates of surgical mortality because they only analyzed deaths occuring in the hospital after surgery. According to HCFA's analysis, in-hospital deaths represent only a fraction of actual deaths after surgery -- for example, in-hospital death figures alone represent only 42% (for Prostatectomy) to 77% (for Coronary Bypass) of total deaths that occur within 1.5 months after surgery. The HCFA data, therefore, is an improvement on many previous estimates of mortality following specific surgeries.

The data show that the highest rate of excess surgery occurs after Coronary Bypass surgery, followed by Reduction of Fractured Femur and Hip surgery. It may, therefore, be particularly important to target these procedures for further efforts to minimize unnecessary surgical interventions. Although Cataract surgery is possibly the most common surgery financed by Medicare, this evidence puts it in a different category than the other surgeries shown on the chart above as far as controlling unnecessary surgery is concerned. Its outcome is better-than-expected mortality, possibly because (a) it is not a very dangerous surgery, and (b) patients who undergo this surgery are a healthier than average group of Medicare beneficiaries. This death rate analysis suggests that efforts to control overutilization of cataract surgery will be rewarded chiefly with financial savings for the HI Trust Fund, rather than improved quality of care for beneficiaries.

Unnecessary Surgery.

Very few studies have attempted to document the extent of unnecessary surgery, particularly because of the conspicuous absence of agreement within the medical profession as to what constitutes the proper indications for a given surgery. This lack of definition and consensus has made it difficult for academic and physician observers to find an "objective" basis for study. Yet, it is necessary to examine this question, including possible incentives for unnecessary surgery, because of skyrocketting rates of surgery for the aged and their greater vulnerability to surgical trauma.

Physicians have economic incentives to prescribe unnecessary surgery. Particularly in the absence of clear guidelines as to the appropriateness of a given surgery, these incentives may encourage doctors to err on the side of surgical, rather than medical/non-invasive therapies.

o A study of physician behavior in response to a change in Medicare payment rates was conducted in Colorado. Researchers estimated that each 10% reduction in payment rates was followed by a 1.4% increase in the number of surgical procedures per patient, a 6% increase in the complexity of services that doctors said they delivered to patients, and a 5% increase in lab tests. (Rice & Gabel papers on physician induced demand; Marshall testimony 11/19/84).

o The "Hastings Center Report" from October, 1983 discussed an incident at a New Jersey hospital, in which an administrative officer of the hospital urged a physician who used cesarean sections sparingly to reconsider his approach, in light of the higher DRG payment for performing cesarean sections.

There is a great deal of disagreement among physicians over when it is appropriate to perform surgery, due to lack of agreement upon uniform and precise indications. While some variation in surgery rates is appropriate, due to characteristics of the local population, there is evidence that individual physician biases and local medical convention are largely responsible for decisions to perform surgery, perhaps playing as much a role as scientific analysis.

o Hysterectomy is performed 80% more often in the South than in the Northeastern United States, and 300% more often in one local area of Vermont than in another area in that State.

o According to Dr. John Wennberg, the researcher who documented the disparity in hysterectomy rates in Vermont, 90% of the 470 Medicare Diagnosis Related Groups (DRGs) show more regional disparity than hysterectomies do.

o At a recent Senate Appropriations subcommittee hearing, Dr. Wennberg projected that if surgery for the removal of the prostate were to be performed nationally at the lowest local rate he had identified, there would be almost 5,000 fewer deaths each year nationwide, compared to the mortality that would occur if the surgery were to be performed nationally at the highest rate he had found.

o A study of rates of surgical variation in Massachussetts found that rates of hernia repair surgery varied by as much as 380% from one region of the State to another, while pacemaker surgery varied by as much as 1250%.

The ongoing debate over unnecessary pacemaker surgery is deeply rooted in the continuing debate over what constitute appropriately conservative indications for implantation. After the Special Committee on Aging held hearings in 1982 at which evidence of 30 to 50 percent overutilization was presented, both the Health Care Financing Administration (HCFA) and a private group of expert cardiologists presented an improved set of criteria to guide physicians in assessing appropriate cases for pacemaker surgery.

o HCFA's revised guidelines are now in use by the Peer Review Organizations. Because of the Senate hearings and subsequent legislation, PROs are required to review all proposed pacemaker implantations. Since July of 1984, these organizations have cumulatively denied 1.5% (333) of the 22,428 proposed surgeries they reviewed.

o The ad hoc cardiology group, however, authors of a recent article in the Journal of the American Medical Association (JAMA), have prepared tighter and more precise guidelines for pacemaker implantation. The authors believe HCFA should again revise its guidelines. Some of them estimate that up to one-third of all pacemaker implantations are still unnecessary and might be recognized as such if the most up to date criteria were utilized by physicians and patients as indication guidelines.

While these widespread disparities in surgical utilization suggest that unnecessary surgery exists, and that the amount of unnecessary surgery may vary from place to place, this lack of agreement on what constitutes appropriate medical and surgical practice has also hampered efforts to create an objective basis for identifying the extent of unnecessary surgery.

Ultimately, howver, the most appropriate definition of unnecessary surgery, is one which acknowledges that the individual confronted with the choice of undergoing surgery should ultimately determine its necessity. This approach makes sense because:

o Individuals must consider their willingness to live with pain, disability, disfigurement and the risk of death, along with their families, work and available social supports, in making a decision to undergo surgery or to accept available alternative medical treatment. These considerations are not objectively definable in the abstract, yet must be considered in any determination of the "necessity" of surgery.

o People do not want the government or their insuror to dictate to them what medical choices they may make.

When individuals have been provided (via a mandatory second opinion program) with the technical information necessary to judge medical factors, they have responded by frequently rejecting surgery. These decisions have cumulatively resulted in dramatically reduced rates of surgery, with no reported ill effects on the people who have elected to forgo surgery. The reductions in surgery rates achieved in this manner are the most powerful and appropriate measure of the extent of unnecessary surgery.

Examples include:

- o Dr. Thomas Graboys' testimony before the Special Committee on Aging indicates that from 50 to 85% of those referred by their own physician for Coronary Artery Bypass Surgery (CABS) will safely opt to be managed medically.
- o State Medicaid programs, and private insurors have been able to reduce targetted rates of surgery by an average of up to 35%.

For further examples, refer to Sections 5, 6, and 7 of this briefing paper, as well as the attached chart, which depicts both high and low rates of reduction of unnecessary surgery, along with projected impact of similar reductions on selected Medicare reimbursed surgical procedures.

Section 4. Private Sector Experience

Use of second opinion provisions, especially the mandatory type, in the private sector has grown by leaps and bounds in recent years. Virtually all of the major group health insurance carriers offer the mandatory second opinion provision in their plans at a reduced premium rate.

Prior to the early 1980s, major insurance carriers had begun to experiment with a voluntary SSOP as a potential cost-saving measure in their plans offered to employer clients. Most of these plans were patterned after the Cornell-New York Hospital program that began in 1972 and was the first large-scale second opinion program.

Several years of experience, however, showed that the voluntary provision was not cost effective and, in the late 1970s, experimentation shifted to the mandatory second opinion and the targeting of a limited number of high volume, high cost elective surgical procedures.

A survey in early 1984 of 1,185 industrial and nonindustrial firms by Hewitt Associates found that 28% of the companies had a mandatory second opinion in their health insurance plans, and an additional 32% had the mandatory provision under consideration. The survey also showed that 53% of the companies surveyed offer 100% coverage to their employees for the cost of a second opinion.

Prudential, the pioneering insurance company with second opinion programs, first offered the mandatory second opinion to its policy holders nationwide in 1980. Prudential reports a current net savings of $6.95 for every dollar spent by its policy holders with mandatory provision. Further, Prudential estimates that, in 1983, its 1,206 inforce plans with second opinion provisions saved an estimated $3.5 million.

Other examples of success with, and growth in the use of, the mandatory second opinion follow:

1. Metropolitan Insurance Companies reports a 26% nonconfirmation rate for its mandatory SSOP and estimates a net savings of $6.00 for every dollar spent to administer second opinion programs;

2. Connecticut General Insurance estimates that, in 1983, overall net savings from mandatory SSOP programs amounted to $10.00 for every dollar spent;

3. Use of the mandatory SSOP among the 65 Blue Cross and Blue Shield plans nationwide rose from 10 in 1982 to 40 in 1983;

4. The number of the Aetna Insurance Company policy holders with a mandatory SSOP rose from 15 in mid-1983 to a current total of 3,164.

Business coalitions on health care have sprung up all across the nation in recent years and are adopting the mandatory second surgical opinion as a cost containment measure. For example, 9, of the 20 member firms of the Toledo Business Coalition on Health Care have adopted the mandatory provision in the past two years.

The Business Council of Pennsylvania, consisting of the chief executive officers of 39 corporations headquartered in Pennsylvania, is advocating a seven-point program for Statewide health care cost containment policy in both the public and private sectors. Among the seven elements is the mandatory second surgical opinion provision.

At least several of the Peer Review Organizations (PROs) recently established by the Health Care Financing Administration for review of Medicare services and procedures administer mandatory second opinions for their private sector clients. The Arizona Pro, for example, has contracts with 44 private firms to operate their health care cost containment programs, and 41 of them use a mandatory second opinion. The Arizona PRO's experience with the mandatory provision in the private sector has been so successful that it has added a mandatory second opinion to its Medicare review.

Section 5. State Experience With The Mandatory Second Opinion

Currently, there are 10 States that have adopted the mandatory second surgical opinion provision for their cost containment programs. They are: Massachusetts; Michigan; Minnesota; Missouri; New Jersey; Wisconsin; Washington; Tennessee; Oregon; and Virginia. The States of New York and Connecticut are working to establish a mandatory second opinion in their Medicaid programs.

The following is a brief synopsis for each of the State Medicaid programs with a mandatory provision;

1. Massachusetts, was the first State to use a mandatory second surgical opinion in its Medicaid program, beginning in 1977, and applied it to eight procedures: Tonsillectomy/Adenoidectomy; hysterectomy; cholecystectomy; submucous resection/rhinoplasty; hemorrhoidectomy; menisectomy; excision and stripping of varicose veins; and disc surgery/spinal fusion. Reductions in surgery rates, for example, were 42% for hysterectomy and 29% for back surgery. A study by the Health Care Financing Administration of the Massachusetts program showed a net savings of more than four dollars for every dollar spent.

2. Michigan implemented its mandatory second opinion in January 1980, and covers seven surgical procedures: cholecystectomy; dilatation and curettage; hemorrhoidectomy, hernia repair; hysterectomy; menisectomy; and tonsillectomy/adenoidectomy. The Medicaid program found that the mandatory provision caused an estimated overall drop in rates of these seven procedures of 35%; and annual cost savings were estimated at $3.7 million.

3. The Minnesota Legislature mandated a mandatory second surgical opinion for the State Medicaid program to become effective on April 1, 1985. The program will cover four procedures: tonsillectomy/adenoidectomy; hernia repair; hysterectomy; and cholecystectomy.

4. Missouri's mandatory second opinion became effective in October 1981 and includes eight procedures: cataract removal; cholecystectomy; dilatation and curettage; hemorrhoidectomy; hernia repair; hysterectomy; laminectomy; and tonsillectomy/adenoidectomy. State Medicaid officials claim that surgery rates for these procedures were reduced overall by 60%; and total expenditures in physician fees for these eight operations fell from $1.7 million in 1981 to $0.75 million in 1984.

5. The Medicaid program in New Jersey added the mandatory second opinion to its cost containment procedures in March 1982 for the following operations: hysterectomy; hernia repair;laminectomy; cholecystectomy; disc surgery/spinal fusion; and tonsillectomy/adenoidectomy. Examples of reductions in surgery rates are: 45% for hysterectomy; 31% for cholecystectomy; and a 28% reduction in hernia repair.

6. Reductions in surgery rates, following adoption of the mandatory second opinion in the Wisconsin Medicaid program, ranged from 17% to 48% for 11 surgical procedures. They

included: cataract extraction; cholecystectomy; dilatation and curettage; hemorrhoidectomy; hernia repair; hysterectomy; joint replacement (hip & knee); tonsillectomy/adenoidectomy; transurethral resection, prostate; and ligation, varicose veins. Medicaid officials estimate that, in 1981, the mandatory second opinion resulted in a savings of $2.8 million.

7. Washington State added the mandatory provision to its Medicaid program in January 1982 . Four surgical procedures were covered: tonsillectomy/adenoidectomy; hysterectomy; hernia repair; and cholecystectomy. The State estimated that there was an overall reduction in surgery rates in these four procedures of 12%, and that the program could expect an annual savings of $656,000.

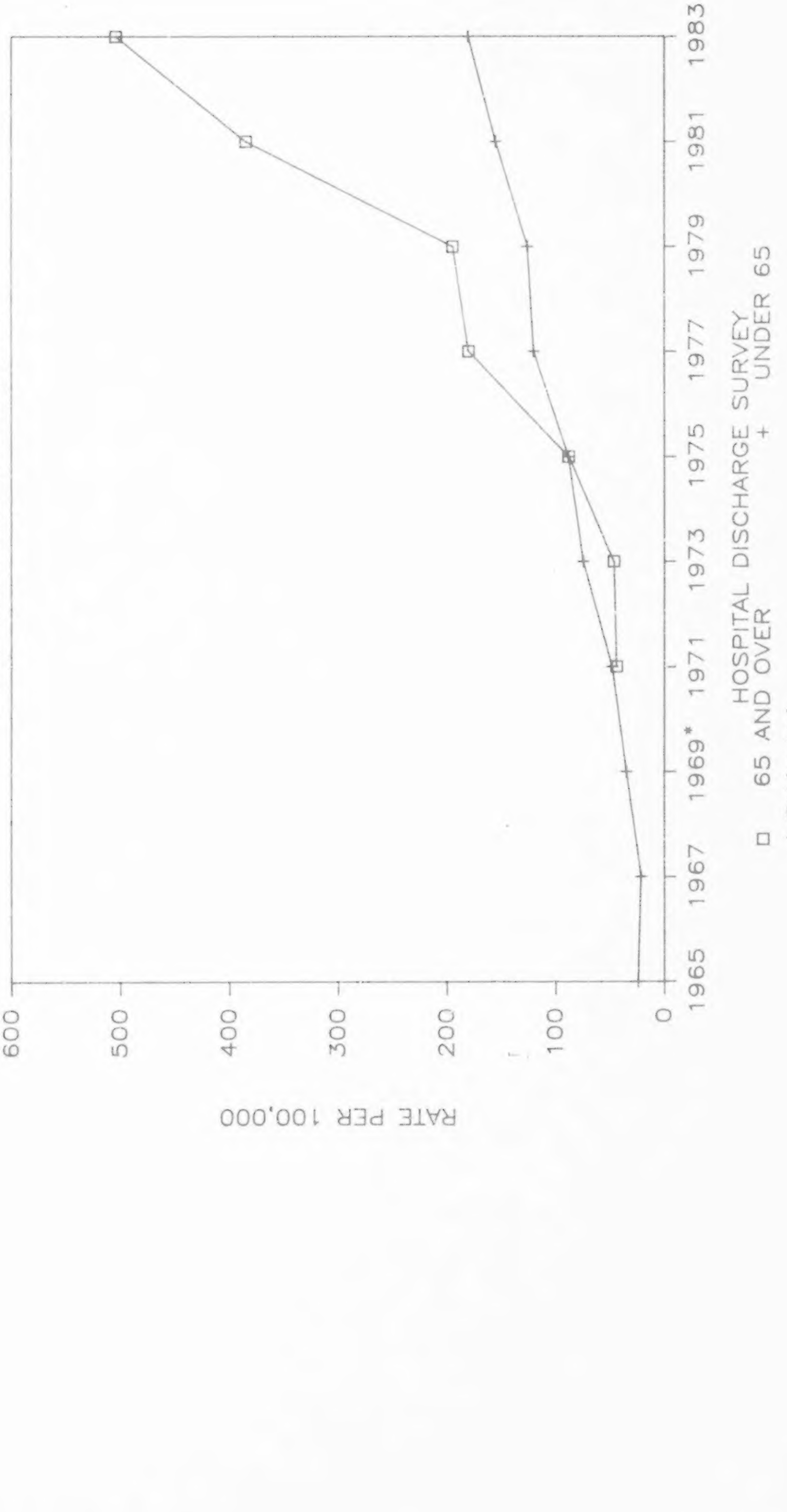
8. The Tennessee Medicaid program incorporated a mandatory second opinion into its cost-savingefforts in October 1984. The procedures covered are Cholecystectomy, hysterectomy, hernia repair, dilation and curettage and tonsillectomy and adenoidectomy. No data, as yet, are available from this program.

9. Oregon's mandatory second opinion was initiated in February 1984. Oregon Medicaid officials project a 14% to 15% overall reduction in surgery rates for 10 procedures: knee surgery; hip joint replacement; menisectomy; prostectomy; hemorrhoidectomy; cholecystectomy; hernia repair; laminectomy; hysterectomy; and cataract removal.

10. Virginia added a mandatory second opinion provision to its Medicaid program in July 1984. Ten procedures require a second opinion: prostatectomy; joint replacement; cholecystectomy; dilation and curettage; hemorrhoidectomy; coronary artery bypass; laminectomy; non-emergency c-section; hysterectomy; and tonsillectomy and adenoidectomy.

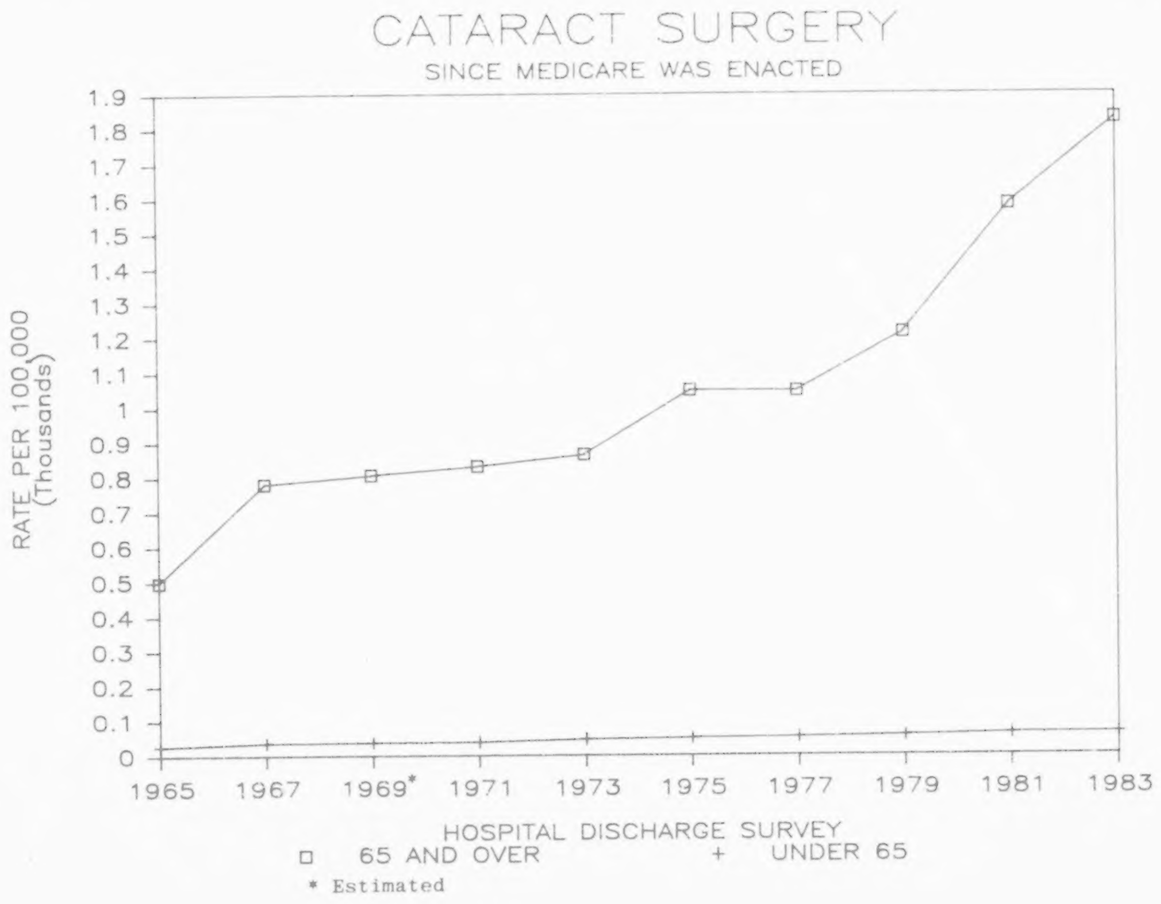
Rates of Surgical Utilization Since Medicare Was Enacted

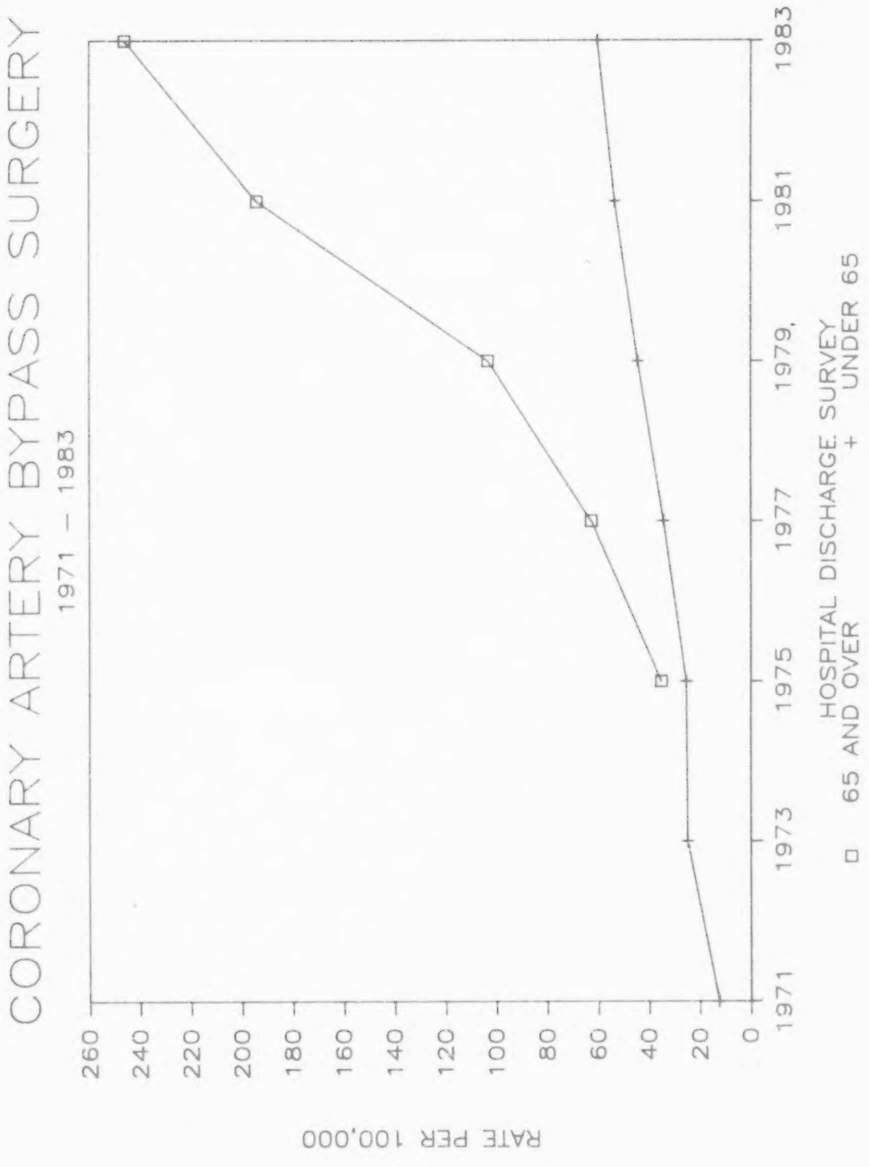
[The following eight charts show how often certain selected surgeries were being performed in the years following the enactment of Medicare in 1965. The charts compare how surgery rates have changed for the aged and non-aged population since the enactment of Medicare. The data was obtained from the National Hospital Discharge Survey for each of the years shown on the charts.]

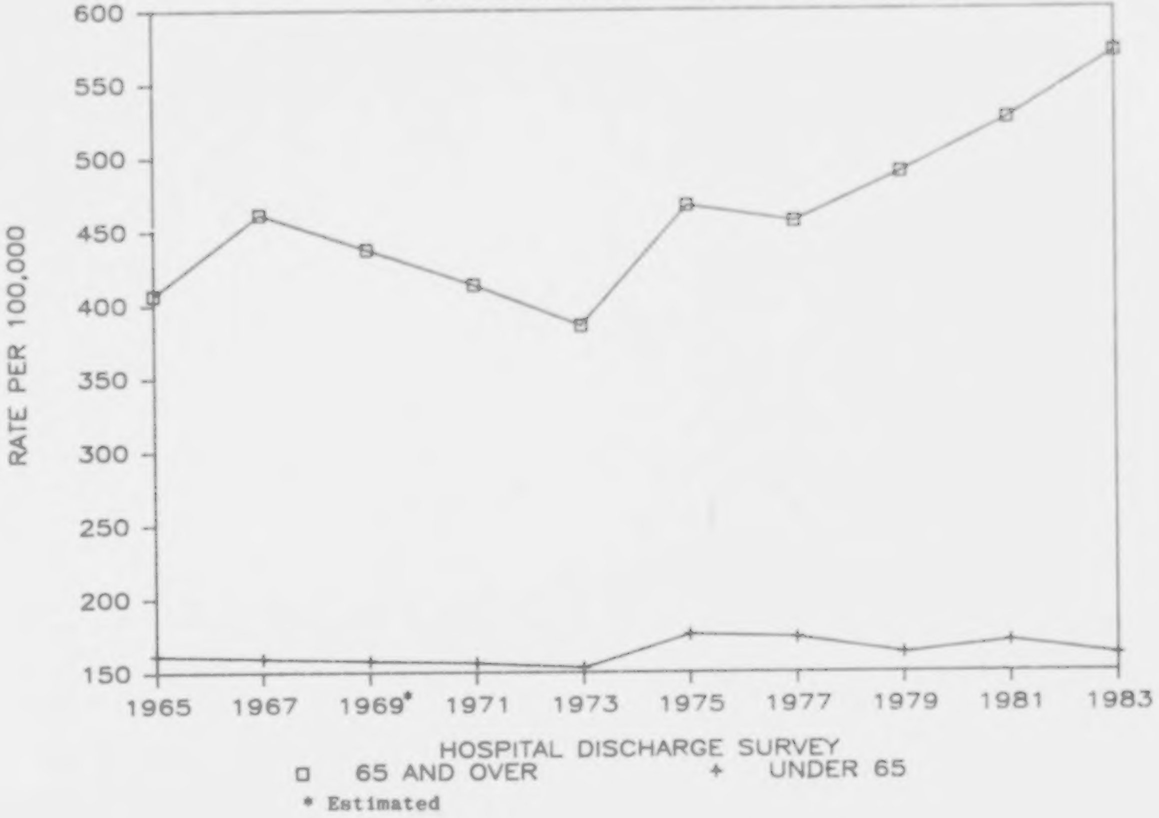


CARDIAC CATHETERIZATION

SINCE MEDICARE WAS ENACTED

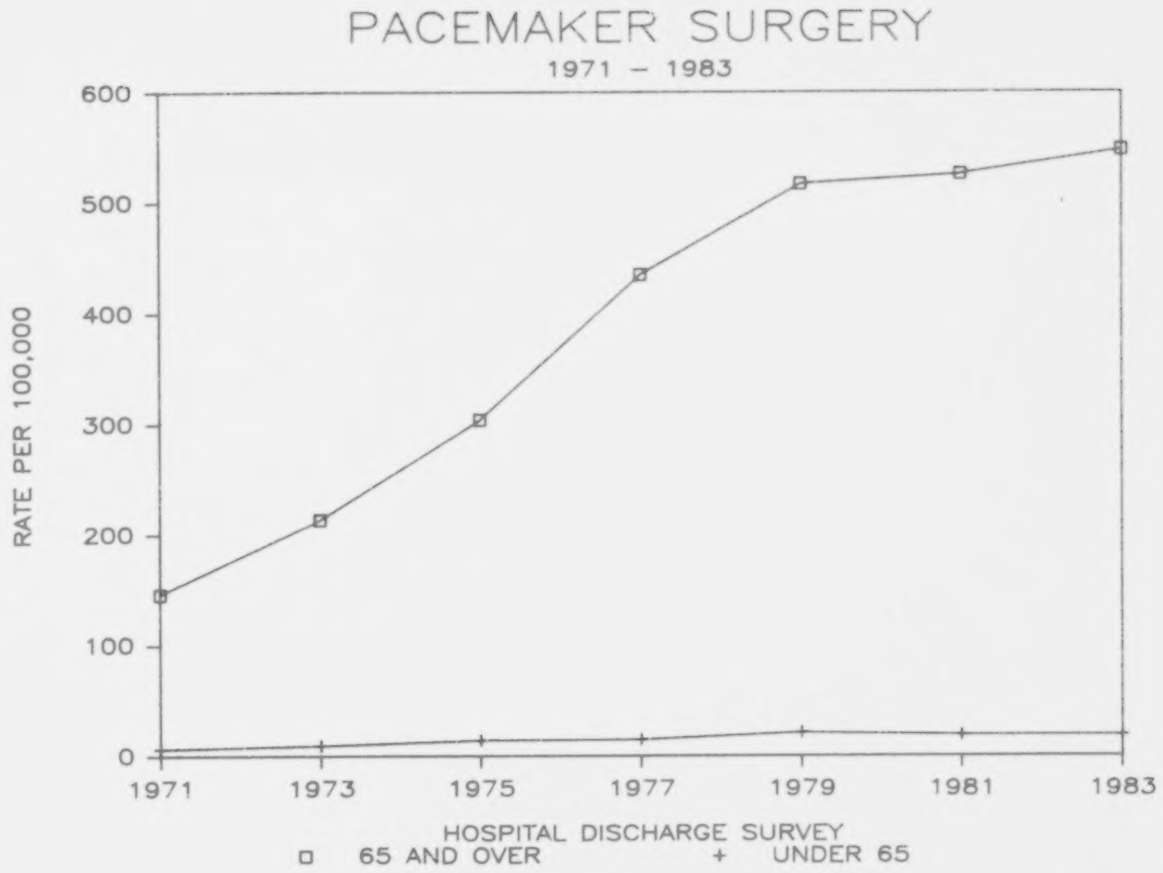

CATARACT SURGERY
SINCE MEDICARE WAS ENACTED
RATE PER 100,000
(Thousands)
1.9
1.8
1.7
1.6
1.5
1.4
1.3
1.2
1.1
1
0.9
0.8
0.7
0.6
0.5
0.4
0.3
0.2
0.1
0
1965
1967
1969*
1971
1973
1975
1977
1979
1981
1983
HOSPITAL DISCHARGE SURVEY
□ 65 AND OVER
+ UNDER 65
* Estimated

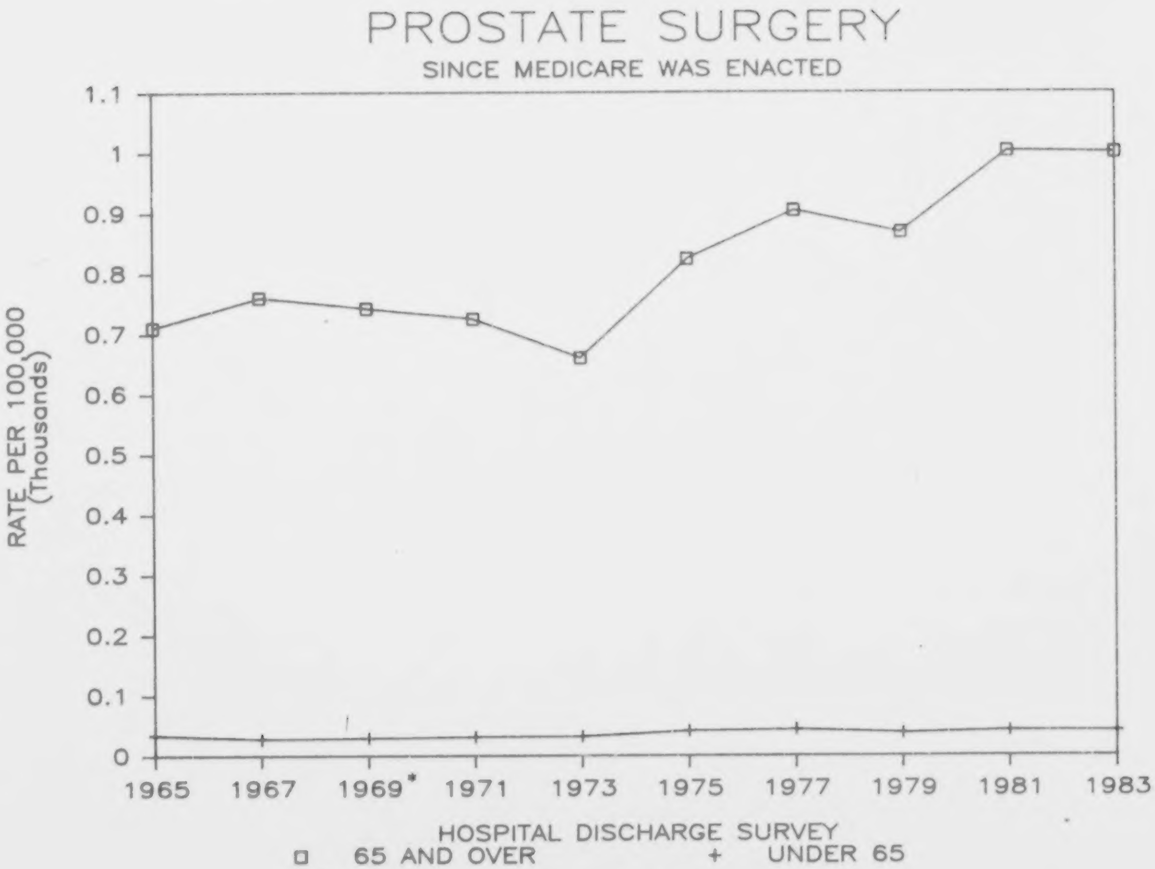

CORONARY ARTERY BYPASS SURGERY
1971 - 1983
RATE PER 100,000
260
240
220
200
180
160
140
120
100
80
60
40
20
0
1971
1973
1975
1977
1979
1981
1983
HOSPITAL DISCHARGE SURVEY
□ 65 AND OVER
+ UNDER 65



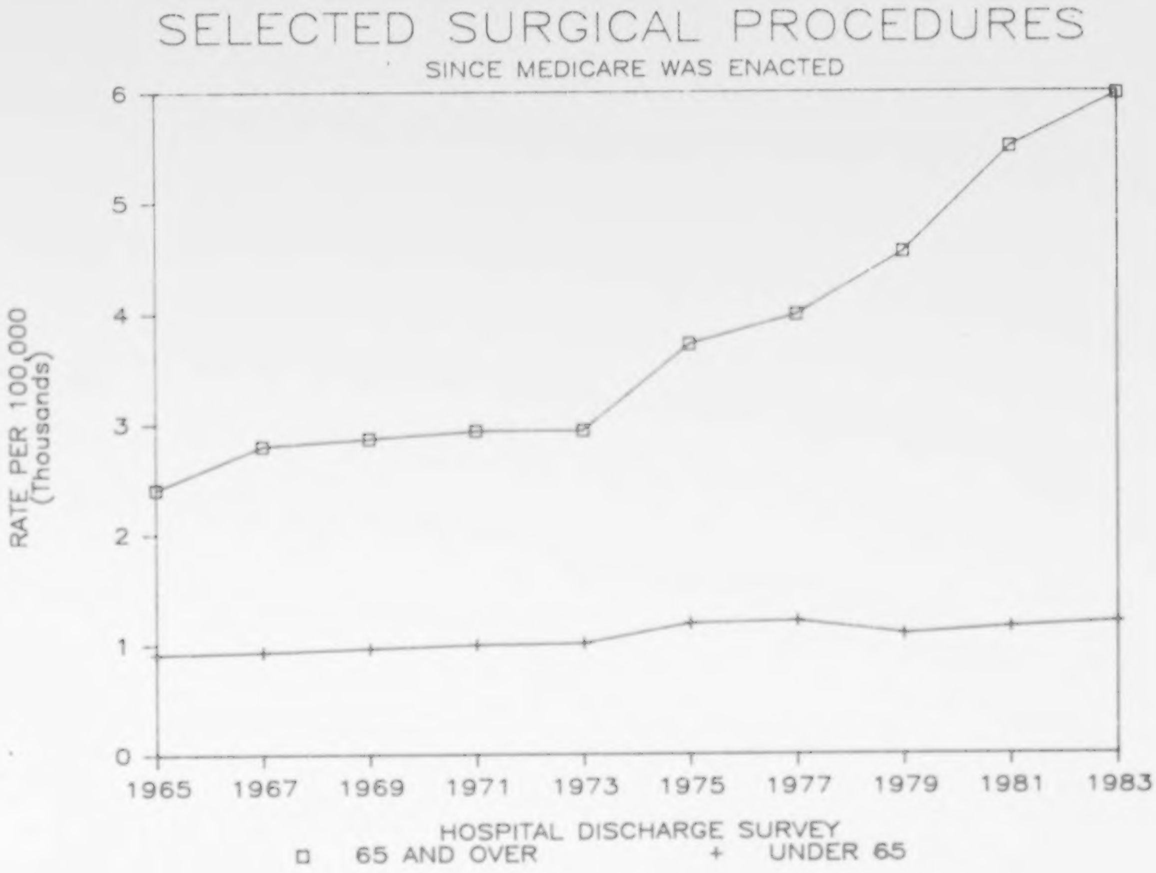
GALLBLADDER SURGERY
SINCE MEDICARE WAS ENACTED

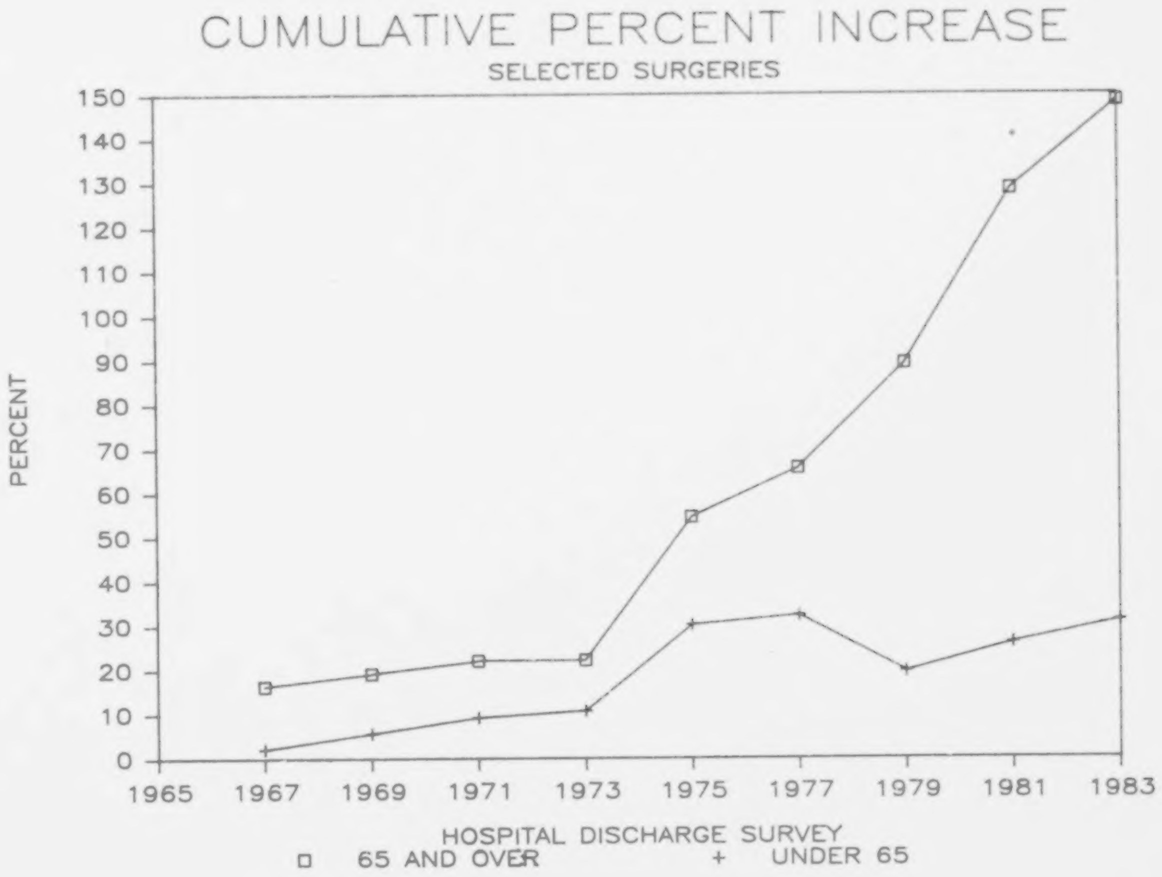
* Estimated


PACEMAKER SURGERY
1971 – 1983
RATE PER 100,000
600
500
400
300
200
100
0
1971
1973
1975
1977
1979
1981
1983
HOSPITAL DISCHARGE SURVEY
□ 65 AND OVER
+ UNDER 65


PROSTATE SURGERY
SINCE MEDICARE WAS ENACTED
RATE PER 100,000
(Thousands)
1.1
1
0.9
0.8
0.7
0.6
0.5
0.4
0.3
0.2
0.1
0
1965
1967
1969*
1971
1973
1975
1977
1979
1981
1983
HOSPITAL DISCHARGE SURVEY
□ 65 AND OVER
+ UNDER 65

* Estimated


SELECTED SURGICAL PROCEDURES
SINCE MEDICARE WAS ENACTED
RATE PER 100,000 (Thousands)
0
1
2
3
4
5
6
1965
1967
1969
1971
1973
1975
1977
1979
1981
1983
HOSPITAL DISCHARGE SURVEY
□ 65 AND OVER
+ UNDER 65


CUMULATIVE PERCENT INCREASE
SELECTED SURGERIES
PERCENT
150
140
130
120
110
100
90
80
70
60
50
40
30
20
10
0
1965
1967
1969
1971
1973
1975
1977
1979
1981
1983
HOSPITAL DISCHARGE SURVEY
□ 65 AND OVER
+ UNDER 65

Since Medicare was enacted, the total rate for eleven major surgeries performed predominantly on elderly patients has increased by 143 percent. These procedures include: cardiac catherization; cardiac pacemaker insertion, replacement, removal or repair; cataract surgery; coronary artery bypass surgery; gall bladder surgery; hemorrhoidectomy; hernia repair; hip surgery; hysterectomy; prostate surgery and back surgery

Rates for some procedures performed on the elderly have increased especially rapidly. For instance, the rate for coronary artery bypass surgery has increased seven times from 35.2 per 100,000 elderly persons in 1975 to 246.3 per 100,000 in 1983. And, the rate for cardiac pacemaker surgery has increased by almost four times from 145.9 per 100,000 elderly persons in 1971 to 547.6 per 100,000 in 1983.

Source: National Center for Health Statistics, Hospital Discharge Survey, 1965 to 1983

The Health Care Financing Administration estimates that direct Medicare spending for surgery represented about $20 billion or 45 percent of total spending for short-stay hospital and physician and related care in 1982 (the latest data available).

APPENDIX 2

Item 1

JOHN HEINZ, PA., CHAIRMAN

PETE V. DOMENICI, N. MEX.
CHARLES H. PERCY, ILL.
NANCY LANDON KASSEBAUM, KANS.
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JOHN MELCHER, MONT.
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JEFF BINGAMAN, N. MEX.

STEPHEN R. McCONNELL, STAFF DIRECTOR
DIANE LIFSEY, MINORITY STAFF DIRECTOR

United States Senate
SPECIAL COMMITTEE ON AGING
WASHINGTON, D.C. 20510

December 13, 1984

The Honorable Margaret M. Heckler
Secretary
Department of Health and Human Services
200 Independence Avenue, S.W., Suite 615F
Washington, D.C. 20201

Dear Madam Secretary:

The U.S. Senate Special Committee on Aging is currently involved in an effort to identify potential areas within the Medicare and Medicaid programs of overutilization of medical services and procedures. To succeed, the Committee will need to rely on maintaining a cooperative working relationship with your Department. In view of our excellent association on other issues of mutual concern, I look forward to working with you in this important endeavor, which I believe will serve in substantial measure to halt the skyrocketing growth of Medicare and Medicaid expenditures.

In order to facilitate and expedite the Committee's inquiry, I am requesting your specific assistance in obtaining access to certain records and files of the Health Care Financing Administration (HCFA) for purposes of review by our Committee's professional staff. The sheer volume of documentation within HCFA makes such access essential in order to avoid unnecessary and overly burdensome requests of HCFA for copies of entire programs and project files. Indeed, I have asked the staff to be highly selective in reviewing and, if necessary, duplicating any records and files that may be needed as evidence in formulating findings, conclusions and recommendations. I have also instructed our Committee's staff to conduct their reviews of the files at the convenience of, and with prior notice to, your personnel so as not to be disruptive. Further, these same accommodations and considerations will apply to Committee staff visits with HCFA personnel.

Separate from the Committee's request for appropriate and necessary access to HCFA files and records, I would very much appreciate your providing to the Committee by December 27, 1984, one copy each of the records and documents identified and described in the attached schedule. Further, the Committee would appreciate receiving these materials on an incremental basis, as they become available for transmittal over the next two weeks.

As the Committee's inquiry may involve matters of a sensitive nature, you have my personal assurance that any and all such information, records and documentation collected by the Committee and its staff will receive appropriate treatment. I would be pleased to apprise you from time to time on our progress and findings.

Should you have any questions regarding the Committee's inquiry, do not hesitate to contact me, or have your staff contact James F. Michie of the Committee staff.

Thank you for your assistance and cooperation.

With warmest regards and wishes for the Holidays,

Sincerely,

John

JOHN HEINZ
Chairman

JH:jmm
Enclosure

Honorable Margaret Heckler
Enclosure

The following is a schedule of documents requested by the Committee and pertaining to the ongoing Health Care Financing Administration (HCFA) project, "Evaluation of the Impact of Second Opinions for Elective Surgery" (contract no. 500-78-0047).

1. A copy of the initial draft of the final study report prepared for HCFA by the project contractor, Abt Associates, Inc., and submitted to HCFA sometime earlier this year.

2. A copy of all HCFA comments pertaining to the draft report described above.

3. A copy of the final report by Abt Associates, Inc., which, according to the HCFA project officer, Alan Friedlob, will be completed and submitted to HCFA by mid-December 1984.

4. A copy of all HCFA comments as they are generated and pertaining to the final project report requested in number 3 above.

5. A copy of the original Request For Proposal (RFP) pertaining to the project and as advertised by HCFA.

6. A copy of the contract/agreement between HCFA and Abt Associates, Inc., all attachments thereto, and all amendments and additions to the contract/agreement executed during the period of from September 1978 to the present.

7. A copy of all documents pertaining to changes in the funding and scope of the project, including the work of the prime contractor, Abt Associates, Inc., and each of Abt's subcontractors, during the period of from 1980 to the present.

8. A copy of all documents pertaining to validation sub-studies that were designed and performed during the period of from 1978 to the present to determine the health outcome of individuals who would participate in mandatory second surgical opinion programs.

9. A copy of a report submitted by project subcontractors to Abt in 1981 concerning confirmation/disconfirmation rates in second surgical programs under study.

10. A copy of all documents pertaining to HCFA comments generated in the first half of calendar 1983 on a draft report by the Health and Human Services Department's Office of Inspector General concerning second surgical opinion programs.

11. A copy of all documents generated and received by HCFA, by the primary contractor and by the primary contractor's subcontractors pertaining to the advisability and need for consulting with those firms and insurance carriers in the private sector that have established voluntary and mandatory second surgical opinion programs.

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

DEC 28 1984

The Honorable John Heinz
Chairman, Special Committee on Aging
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

The Department of Health and Human Services shares your concern regarding overutilization of medical services and procedures within the Medicare and Medicaid programs. As your staff can see from the documents being provided to them and from their recent visit to the Health Care Financing Administration's (HCFA) offices in Baltimore, the Department has a number of activities underway. In addition, the recently implemented Peer Review Organizations (PROs) have developed performance objectives which address your concerns. The efforts of these medical review organizations working at the State and local level will greatly extend our ability to ensure appropriate utilization of health care services.

I am pleased to supply the information you requested within the desired timeframe. Included in this information is the draft report "Evaluation of the Impacts of Second Surgical Opinions for Elective Surgery." This draft is being reviewed within HCFA and when that process has been completed, a final report will be prepared. In response to Items 2, 3, and 4, both the comments and the final report will be forwarded to your staff when they are available. No materials are included for Item 11. Several telephone conversations have taken place between HCFA staff and private organizations which have second surgical opinion programs. There are no documents in HCFA files regarding these discussions as they were held on an informal basis.

Your consideration of the demands on my staff is greatly appreciated. I believe that your staff can obtain the information they need with some mutual cooperation. As you know, written requests are the most expeditious means for obtaining information and I suggest we continue to use this method whenever possible. If it becomes necessary for your staff to visit the HCFA Baltimore offices, we would appreciate your willingness to schedule the visit in advance and outline your needs with Ms. Cynthia Root, Acting Assistant Secretary for Legislation. Whether it is by letter or personal visit, we will make every effort to supply your office with any information you require.

We look forward to working with you in your efforts to control rapidly increasing health care costs.

Sincerely,

Margaret M. Heckler

Margaret M. Heckler
Secretary

Item 2

JOHN HEINZ, PA., CHAIRMAN

PETE V. DOMENICI, N. MEX.
CHARLES H. PERCY, ILL.
NANCY LANDON KASSEBAUM, KANS.
WILLIAM S. COHEN, MAINE
LARRY PRESSLER, S. DAK.
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STEPHEN R. McCONNELL, STAFF DIRECTOR
DIANE LIFSEY, MINORITY STAFF DIRECTOR

United States Senate
SPECIAL COMMITTEE ON AGING
WASHINGTON, D.C. 20510

January 29, 1985

The Honorable Margaret M. Heckler
Secretary
Department of Health and Human Services
200 Independence Avenue, S.W., Suite 615F
Washington, D.C. 20201

Dear Madame Secretary:

I am writing to request your assistance in obtaining additional records and documents essential to the Committee's ongoing inquiry into utilization of Medicare and Medicaid services and procedures. These materials are reposited in the files of Health Care Financing Administration (HCFA), and are identified and described in the attached schedule.

I would very much appreciate receiving copies of these materials by close of business on February 1, 1985.

Thank you for your continuing cooperation and assistance.

Warm regards,

John Heinz

JOHN HEINZ
Chairman

JH:jss
Enclosure

SCHEDULE OF DOCUMENTS REQUESTED BY THE SPECIAL COMMITTEE ON AGING

1. Any and all versions, including drafts, of the PRO Directive #4, pertaining to Medical Review Implementation.

2. Any and all comments, both solicited and unsolicited, received by HCFA concerning the documents identified above in item #1.

3. Any and all versions, including drafts, of PRO Directive #6, pertaining to Admission Pattern Monitoring.

4. Any and all versions, including drafts, of a PRO Directive that would pertain to certain procedures that have been adopted by several PROs and which may be characterized as attempts by these PROs to implement mandatory second surgical opinion programs.

5. Any and all versions, including drafts, of a policy and/or procedure for witholding and/or suspending payments to, and/or terminating, PROs which fail to meet their contractual obligations to HCFA.

6. Any and all versions, including drafts, of a policy and/or procedure entitled Peer Review Organization Monitoring Protocol and Tracking System ("PROMPTS"), plus internal memoranda, including drafts, which discuss this system and/or the need for such a system.

7. Any and all versions, including drafts, of summary reports generated by HSQB and BPO pertaining to the findings of on-site HCFA visits to PROs, including tables, charts and other data used in preparation of such reports.

8. Any and all versions, including drafts, of memoranda addressed to Carolyne Davis pertaining to the status of PRO implementation, including but not limited to Reports by the PPS Monitoring Committee.

9. Any and all versions, including drafts, of memoranda or reports prepared by HCFA personnel and pertaining to meetings or telephone conversations involving HCFA personnel in Seattle on or about December 12 and 13, 1984.

10. Any and all versions, including drafts, of reports based upon analysis of information contained in PRO Monthly Activity Reports and PRO Quarterly Progress Reports, and generated by the Data Analysis Branch of the Office of Medical Review, HSQB.

11. Any and all versions, including drafts, of memoranda or reports pertaining to PRO Contracts Objectives Modifications.

Item 3

JOHN HEINZ, PA., CHAIRMAN

PETE V. DOMENICI, N. MEX.
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STEPHEN R. McCONNELL, STAFF DIRECTOR
DIANE LIFSEY, MINORITY STAFF DIRECTOR

United States Senate
SPECIAL COMMITTEE ON AGING
WASHINGTON, D.C. 20510

January 31, 1985

The Honorable Richard P. Kusserow
Inspector General
Department of Health and Human Services
330 Independence Avenue, S.W.
Washington, D.C. 20215

Dear Mr. Kusserow:

I am writing to request your assistance in the Committee's inquiry into overutilization of medical services and procedures in Medicare and Medicaid.

I am especially concerned over the longstanding problem and associated costs of unnecessary surgery that continue to threaten the health and welfare of America's elderly. My concern was heightened by your report to the Congress last November on this very subject; and, therefore, I initiated a Committee staff inquiry into the efforts of the Health Care Financing Administration (HCFA) to determine whether there is a need for second surgical opinion programs (SSOPs) in the Medicare and Medicaid systems.

HCFA recently completed a six-year study on this issue and has drafted a report, "Second Surgical Opinion Programs: Public Policy Alternatives." I would very much appreciate your reviewing the HCFA report and sharing with the Committee your thoughts and views regarding the findings and conclusions of the report. In particular, I am interested in knowing whether your previous recommendation on the need for mandatory second surgical opinion programs in the Medicare and Medicaid programs is in any way altered by the HCFA study and report.

Please find enclosed a copy of the HCFA draft report. As it is still in draft form, I would appreciate your not releasing any of the contents.

It would be most helpful if you could provide your comments to the Committee by close of business on February 5, 1985.

Thank you for your cooperation and assistance in this matter.

Warm regards,

John Heinz

JOHN HEINZ
Chairman

Enclosure
JH:jmm

DEPARTMENT OF HEALTH & HUMAN SERVICES
Office of Inspector General

FEB 14 1985

The Honorable John Heinz
Chairman, Special Committee on Aging
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

Your letter dated January 31, 1985 requested our comments on the Abt Associates Inc., draft report on second surgical opinion programs (SSOPs). You specifically wanted to know if the Abt study altered recommendations contained in a prior Office of Inspector General (OIG) report on this subject.

As you know, the Abt study is in draft form and does not contain certain sections such as the summary of findings which, we understand, will be submitted to the Health Care Financing Administration (HCFA) at a later date. Because of the tentative nature of this report, we contacted the contractor's project director who is the principal author to confirm our interpretation of the report's conclusions.

Based on that discussion and our review of the draft report, we believe that the findings show that mandatory SSOPs reduce the rate of elective surgery, are cost effective, and have no adverse direct effect on the health of program participants. In this connection, the report concluded that voluntary programs had little effect on reducing the rate of elective surgery. Cost savings were also minimal due to the small number of beneficiaries involved. In contrast, mandatory SSOPs resulted in substantial reductions in the rate of surgery ranging from 9 percent to 30 percent. The findings also show that the results of the study can be reasonably applied to both Medicare and Medicaid.

Page 2 - The Honorable John Heinz

The Abt study, and our conversation with the project director, therefore confirm the findings and conclusion of the OIG report that mandatory SSOPs in Medicare and Medicaid can reduce the rate of elective surgery and the cost of health care without adversely affecting the health of program recipients.

I have requested HCFA to furnish my office a copy of the final report when received. After reviewing the final report and HCFA's response, I will be happy to provide you additional comments.

Sincerely yours,

Richard P. Kusserow
Inspector General

Item 4

JOHN HEINZ, PA., CHAIRMAN

PETE V. DOMENICI, N. MEX.
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NANCY LANDON KASSEBAUM, KANS.
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JEFF BINGAMAN, N. MEX.

STEPHEN R. McCONNELL, STAFF DIRECTOR
DIANE LIFSEY, MINORITY STAFF DIRECTOR

United States Senate
SPECIAL COMMITTEE ON AGING
WASHINGTON, D.C. 20510

March 1, 1985

The Honorable Margaret M. Heckler
Secretary
Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Dear Madame Secretary:

As Chairman of the Special Committee on Aging, I am requesting that you appear before the Committee on the morning of March 14, 1985, to testify before the Committee at a hearing concerning the Committee's inquiry into overutilization of medical services and procedures in the Medicare and Medicaid programs.

Your Department's efforts to control skyrocketing medical costs through the recently established Peer Review Organizations (PROs) are to be commended. While the PROs are still very new, I am confident, as I know you are, that they will be helpful in containing costs and improving quality of care.

The focus of the hearing is not on the performance of the PRO system. Rather, the Committee is concerned with the question of how best to prevent unnecessary surgery. Our investigation has found that many organizations and agencies in both the public and private sectors have attempted to contain unnecessary surgery by implementing a mandatory second surgical opinion provision (SSOP) in their employee and retiree group health insurance plans. Data and information from these programs show that the mandatory SSOP, when applied to a limited number of high volume and high cost elective surgical procedures, may reduce surgery rates by as much as 30%. These findings were confirmed by a recently completed study of SSOPs sponsored by the Health Care Financing Administration (HCFA). HCFA's examination of the Massachusetts Medicaid Program's experience with a mandatory SSOP showed an overall savings of $4.30 for every dollar spent. Moreover, the Department's Office of Inspector General in its most recent report of November 1984 reiterated its cost-saving recommendation "that HCFA seek a legislative change to the Social Security Act that would require Medicare and Medicaid beneficiaries to seek a mandatory second surgical opinion for selected surgeries."

More important than saving money, however, is the need to protect the health and welfare of those who might undergo unnecessary and life-threatening surgery. I am concerned, as I know you are, that the per capita rate of surgery for older Americans grew by 58% between 1965 and 1977, a rate twice that of those under age 65. Second surgical opinions in the Medicaid and Medicare programs may help slow the growth in surgeries for elderly beneficiaries.

In light of these facts, the Committee would very much appreciate receiving your thoughts and views on the feasibility of implementing a mandatory SSOP in the Medicare and Medicaid programs. Specifically, the Committee would like you to address the following questions and issues:

1. What is the Department's reaction to the Inspector General's recommendation in favor of a mandatory SSOP in the Medicare and Medicaid programs and to the findings of the HCFA seven-year study of SSOPs?

2. In light of the findings of the HCFA study of SSOPs and the recommendation of the Inspector General, is the Department prepared at this time to commit to serious and expeditious consideration of a mandatory SSOP in the Medicare and Medicaid programs?

3. Does the Department see a need to amend the Social Security Act for implementation of a mandatory SSOP in the Medicare and/or Medicaid programs, and, if so, in what respect(s)?

4. Federal Law permitting, could a mandatory SSOP be added to the existing utilization review performed by the PROs?

5. If mandated by the Congress, what is the Department's preference for implementing a mandatory SSOP in the Medicare and Medicaid programs? Should it be implemented simultaneously in all States? Should it be phased in gradually in all of the States? Or should there be a demonstration project for a set period with concurrent research study and monitoring to measure results?

The hearing is scheduled to begin at 9:30 a.m. on March 14, 1985, in room SD-562 of the Dirksen Senate Office Building. It would be most helpful if you could provide the Committee with 10 copies of your prepared testimony on March 11, 1985, and 100 additional copies on the morning of the hearing.

Should you have any questions regarding the hearing, do not hesitate to contact me or have your staff contact Jim Michie or David Schulke of the Committee staff at 224-5364.

Thank you for your continuing cooperation and assistance.

Warm regards,

John Heinz

JOHN HEINZ
Chairman

JH:jms

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

The Honorable John Heinz
Chairman
Special Committee on Aging
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

Secretary Heckler has asked me to respond to your invitation to testify at the March 14 hearing on overutilization of medical services and procedures in the Medicare and Medicaid programs.

The Secretary regrets that she will be unable to participate in this hearing. Mr. James Scott, Acting Deputy Administrator, Health Care Financing Administration, will represent the Department.

We look forward to sharing our views with you on this important issue.

Sincerely,

Lawrence J. DeNardis
Acting Assistant Secretary
for Legislation

APPENDIX 3

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Memorandum

Refer to: BPO-P33

Date NOV 30 1982

From Director
Bureau of Program Operations

Subject Office of Inspector General Draft Report-A Mandatory Second Surgical Opinion Would Prove Beneficial to the Medicaid and Medicare Programs (ACN 03-31211)(Your Memorandum Dated 11/18/82)--INFORMATION

To Director
Office of Executive Secretariat

We believe the subject report does not contain sufficient analysis to document the cost savings estimated by the Inspector General's Office if Medicare and Medicaid required their beneficiaries to obtain second opinions for selected types of surgeries as a condition of payment. Therefore, we cannot endorse the Inspector General's (IG) recommendations for a mandatory second surgical opinion program (SSOP) for selected types of surgeries at this time. Below are a few questions we believe should be addressed.

- Are the estimated savings based solely on the sentinel effect?
- Were the administrative and program costs of such a program offset against the savings?
- What was the confirmation rate in the voluntary and mandatory programs? How will the confirmation rate in a mandatory program affect the cost savings?
- In those States in which a second opinion did not confirm the first opinion, and the beneficiary had the option of having the surgery performed without a third level of review, what percentage of the beneficiaries had the surgery performed? Also, in those cases in which the patient decided against having an operation based on the second opinion, what percentage of the beneficiaries had the surgery performed within a year after the second opinion?

We also believe certain policy questions should be analyzed before deciding on the recommendation. Some of these questions follow.

- If a beneficiary does not have a second opinion, who is at risk? Can the surgeon or the hospital be held just as liable as the beneficiary?
- During the demonstrations, second opinion consultations were furnished by a selected panel, and if a beneficiary went to a doctor not on the panel, the consultation was not covered. Does the IG recommendation foresee using for the consultation a special panel, or any doctor?

- In Massachusetts, if the second opinion differed from the first, a Medicaid beneficiary had to have a third consultation. Are States going to be allowed to enforce a third opinion?
- Would mandating a SSOP be counter to the Administration's desire that States should have more flexibility in executing all programs?

Finally, we have questions on the operational issues that should be addressed before endorsing the recommendation.

- Did the IG note any difficulties in keeping track of the waived deductibles and copayment requirements in their review?
- Would the program be acceptable to the Medicare and Medicaid beneficiary community?

For the reasons stated above, the Bureau of Program Operations cannot accept the IG recommendation at this time.

RG Howard
for John C. Berry

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care
Financing Administration

Memorandum
Refer to: FPC-11
285

Date DEC 0 1 1982

From Acting Director
Bureau of Quality Control

Subject Office of Inspector General Draft Report—A Mandatory Second Surgical Opinion Would Prove Beneficial to the Medicaid and Medicare Programs (ACN 03-31211)—INFORMATION

To Director
Office of Executive Secretariat
Attention: Audit Liaison Staff

The Bureau of Quality Control strongly supports the conclusions and recommendations of the subject draft report. Our Office of Financial Analysis (OFA) has also been conducting research on second surgical opinion programs, and the project has reached the draft report stage. A copy is attached for your consideration and use as added support for your recommendations. The OFA staff is concluding their research on this project, as the OIG's report is further along in gaining clearance. We offer to share all or part of OFA's data base to support the OIG's report.

Ed Moore for
John C. Berry

Attachment

ROOM 732
ROOM 562

SURGERY SECOND OPINION CONSULTATION PROGRAM

DRAFT

1/20/83

Prepared by:
Division of Program Financial
Analysis
Office of Financial Analysis
Bureau of Quality Control
Health Care Financing Administration

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I. INTRODUCTION

National expenditures for physicians' services in 1980 totalled $46.6 billion, up 87 percent from 1975. The Medicare and Medicaid programs experienced similar increases. Medicare Part B physician payments rose 133 percent from $3.3 billion in 1975 to $7.7 billion in 1980. Over the same period, Medicaid physician payments increased 46 percent, from $1.3 billion to $1.9 billion.

Increases in program payments for physicians' services are attributable to two major influences: (1) unit price increases (physician price inflation rate averaged 10.18 percent per year during the period) and (2) increased use of services. It is the utilization side of the cost problem with which this report is primarily concerned. The United States has the highest rate of surgery in the world. It also has the highest number of surgeons per capita. There has also been substantial growth in per capita surgical rates, increasing by 31 percent from 71 per thousand population in 1968 to 93 per thousand in 1977. Various explanations have been offered to account for the increases: accessibility of medical care, development of new technology and treatment procedures, and growth of third-party payments. Another factor is the alleged "supply push" expansion in patient admissions to fill beds, operating suites, and surgeons' time.

The main tools used in the effort to control Medicare physician costs have been fee regulations and utilization controls. Their effectiveness may be hampered by the structure of the medical services' market. Major characteristics of the competitive market are absent there. Consumer knowledge of the product and alternatives to it are limited in the extreme. Product differentiation is the rule, and qualitative factors rather than price dominate the consumer decision process. When seeking medical services, the consumer must rely on the physician's judgment. The physician in many respects serves as the consumer's agent in the medical marketplace, making decisions as to what care to purchase and from whom to purchase it. The economic anomoly of this role is that the same physician is frequently the supplier of those services.

In 1978, the Department initiated a voluntary second opinion program, the National Surgery Second Opinion Program (NSSOP). From an economic standpoint, the second opinion program offered a means of modifying the doctor-patient consumer decision process to better approximate the characteristics of the competitive marketplace, where the consumer is fully informed of the array of available purchase options.

The program entails: (1) a public relations effort to encourage persons who have been advised by their physicians that surgery is necessary to seek the opinion of a second physician on the necessity for surgery and (2) establishment and maintenance of a toll free hotline to advise individuals on how to contact a local physician referral service (usually the State medical society). During 1981, HCFA's cost of administering the NSSOP was approximately $100,000, and Medicare paid about another $300,000 in connection with beneficiaries' medical examinations generated by the program.

The purpose of this project was to determine whether or not the HHS surgical second opinion program is cost effective.

II. EXECUTIVE SUMMARY

The findings of the study support the conclusion that the HHS surgical second opinion program:

1. is cost effective in the three States examined, the cost benefit ratio was 16:1 and;
2. has not been aggressively implemented or monitored. Four States with only 20 percent of the Medicare population accounted for 97 percent of the volume of surgical second opinions reported nationally. Standardized reporting requirements have not been enforced. Only 1,636 second opinions were purchased in 1981, compared with 11.4 million surgical procedures performed.

Other studies summarized in this report also support the conclusion that a well structured surgical second opinion program will produce substantial program savings, by providing a closer approximation of the competitive marketplace through enhanced consumer awareness of less risky and less expensive treatment modalities.

Based on the above conclusions, this report recommends a sharp step-up in the HHS voluntary second opinion program, including increased publicity, more rigorous reporting requirements, and an organizational focal point having responsibility for the program. It also recommends regulations to permit Medicare payment of deductibles and coinsurance for second opinions to reduce the economic disincentives to doctors and beneficiaries.

Over the longer run, the report recommends development of a mandatory second opinion program for Medicare (and for Medicaid at the States' option) to cover selected elective inpatient procedures.

III. METHODOLOGY

The hypothesis of the study was that surgical second opinions are not cost effective as measured by the ratio of the savings from avoided surgeries to the cost of the second opinion program.

The effect of surgical second opinions on the national cost and rate of surgery is not amenable to macroanalysis because the measurable volume of second opinions has been so small. For the 12-month period ending January 31, 1982, only 1,636 surgery second opinions were reported. This amounted to only 1 second opinion for every 7,000 surgical procedures. In terms of dollars, about $295,000 was spent on second opinions, while surgeons' charges accounted for $3.65 billion. Carrier service areas were selected as the most agreeable units for the testing of the study's hypothesis on a microanalysis basis.

There were two major phases of the study. The first was an analysis of direct cost savings to Medicare resulting from surgical second opinions and the second was a review of the literature on the subject to determine if it contained any information or insights which might be applicable to Medicare.

Part B bill payment records for the 4 months ending May 31, 1981 were analyzed to identify carrier service areas experiencing the largest volume of second opinion payments . Five carriers were selected: Connecticut General Life, New Jersey Prudential, Pennsylvania BS, California BS, and California Occidental. Based on payment record data, these carriers accounted for $138,729 in payments for second opinion consultants, or 97 percent of all such payments during the period. All five were contacted with requests for paid claims history files for beneficiaries receiving second opinions. However, due to budgetary restraints, unavailability of data, and other difficulties, only New Jersey Prudential, Connecticut General Life and Pennsylvania Blue Shield were able to respond with timely, useful information.

For each beneficiary who received a surgical second opinion from January 1980 - May 1981, the contractors supplied procedure and reimbursement data from paid claims history files. This was used to determine whether or not the beneficiary underwent surgery within 6 months after receiving the second opinion.
Average surgical charges in each State were developed by dividing the total allowable surgeons' charges for patients receiving a second opinion by the number of patients receiving surgery. Avoided surgeons' charges were estimated by multiplying the number of beneficiaries who did not undergo surgery following a second opinion times the average surgeon's charge for those who did undergo surgery.

This methodology for estimating progam cost savings is conservative in that it considers only surgeons' fees on the savings side of the formula. It ignores larger hospital cost savings as well as more modest ones associated with anesthesiology, pathology, radiology, and a range of other professional services connected with surgery. On the other hand, savings estimates take no account of the cost of alternative treatment modalities. Also, the assumption of a causal relationship between a second opinion and the absence of surgery is not necessarily valid in all cases. To the extent that assumption is not valid, savings may be overstated. The very small proportion of second opinions in itself raises a question as to whether these individuals had some systematic predisposition against surgery and would have tended to forgo surgery even in the absence of a second opinion. On balance, though, the methodology appears to yield a conservative approximation of savings.

Published studies from HCFA's Office of Research, Demonstrations and Statistics (ORDS) provided the core of the literature used for information on various second opinion programs and national medical expenditure data. The ORDS studies used were *Eight Years' Experience with a Second Opinion Elective Surgery Program: Utilization and Economic Analyses*, *The Effect of a Mandatory Second Opinion Program on Medicaid Surgery Rates - An Analysis of the Massachusetts Consultation Program for Elective Surgery*, and *Physician - Induced Demand for Surgical Operations*. General information sources included the *1980-1981 Source Book of Health Insurance Data* prepared by the Health Insurance Institute, Washington, D.C. and *The Medicare and Medicaid Data Book, 1981* published by HCFA's Office of Research and Demonstrations, April 1982.

TABLE I
SURGERY SECOND OPINIONS BY QUARTER
FEBRUARY 1981 - JANUARY 1982

	FEB-APRIL 1/30-4/24	MAY-JULY[1] 4/25-7/31	AUG-OCT. 8/1-10/30	NOV.-JAN. 10/31-1/29	TWELVE MONTH TOTAL
SURGERY:					
Expenditures	$855,957,958	$865,335,016	$929,394,498	$996,496,120	$3,647,183,592
Frequency	2,553,690	2,764,751	3,011,719	3,152,803	11,482,963
SECOND OPINIONS:					
Expenditures	$ 109,909	$ 94,607	$ 50,405	$ 40,493	$ 295,414
Frequency	510	488	360	278	1,636

Source: Part B Bill Payment Records Received, Accepted, and Posted to Beneficiaries' Accounts at HCFA

Footnotes:

1. Data for 6/20 -26/81 and 7/27/81 were lost through a systems malfunction

TABLE II
SECOND OPINIONS
EXPENDITURES AND VOLUME
FEBRUARY - MAY, 1981

	EXPENDITURES		VOLUME	
	$	%	#	%
U.S. Total	142,665	100.00	703	100.00
5 CARRIER TOTAL	138,729	97.24	625	88.91
1. Conn Gen'l. Life	434	.30	12	1.71
2. N.J. Prudential	631	.44	13	1.85
3. PA. BS	2,781	1.95	53	7.54
4. Calif. BS	5,338	3.74	81	11.52
5. Calif. Occidental	129,545	90.81	466	66.29

Source: Part B Bill Payment Records Received, Accepted, and Posted to Beneficiaries Accounts at HCFA for the period February - May 1981.

IV. FINDINGS

A. The Medicare Experience

1. The Second Opinion Program is Cost Effective

As indicated in Table III, the Connecticut, New Jersey and Pennsylvania experience from January 1980 - May 1981 supports a conclusion that the second opinion program has been highly cost effective. For the 200 beneficiaries who obtained second opinions in the three States in the period, 128 beneficiaries or 64 percent showed no indication of surgery in their records within 6 months after obtaining the second opinion. The total allowable charges for the 200 second opinion consultations were $7,789. The savings in avoided surgeons' charges were $125,168. This equates to savings of $16 for every benefit dollar spent on second opinions. The net savings of $125,000 in the three States covers 125 percent of the $100,000 total administrative cost of the program for the entire nation.

Obviously, the above data do not provide a basis for a firm conclusion on the cost effectiveness of second opinions. The cases reviewed are not a representative sample. These cases were included and others excluded from the study simply on the basis of practical availability of information in a reasonable timeframe. The payment record file was not designed to provide the kind of information required to reach a valid conclusion in this type of study (Appendix 1). Causality is not established. Is failure to undergo surgery following a second opinion the direct result of the second opinion? Does as high a proportion of persons forgo recommended surgery in the absence of a second opinion? What was the cost of alternative treatments undergone as a result of second opinions? Many of these types of questions are not answerable from available data sources, but the conservative estimation technique used (see Methodology) and the corroborative evidence of other studies adds substantially to the confidence that can be placed on the results of this three-State study.

2. Impact of the Program is Minimal

Although the Department's second opinion program has been highly cost effective, its impact has been inconsequential and spotty. The hotline handles approximately 120,000 requests per year for the phone numbers of local referral services. Regional data for 1981 show only 6,325 inquiries reported by the local referral services (Table IV).

Further reflecting the minimal impact of the program, a total of only 1,636 payments for Medicare second opinions were reported for the 12 months ending January 31, 1982. This averages only 1 second opinion for every 7,000 surgical procedures performed. Impact was also highly concentrated in just a few geographical areas. Four States accounted for 97 percent of the expenditures and 87 percent of the volume of second opinions (Table II).

Little management attention has been given to the program. The total administrative expenditures for the program are about $100,000 (less than the annual cost of photocopy and computer tab paper in HCFA central office). Most of the amount goes to the operation of the national hotline. There is no monitoring system for assessing results and recommending actions to improve them. Indeed, there is no reliable data base upon which to base such assessments. This is reflected in the extensive reservations regarding the accuracy of the data used for this report as summarized in Appendix 1.

TABLE III
AVOIDED SURGERY SAVINGS
NEW JERSEY AND CONNECTICUT
JANUARY 1980 - MAY 1981

	CONNECTICUT		NEW JERSEY		PENNSYLVANIA		TOTAL	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Beneficiaries Receiving a Second Opinion	30	100.0	97	100.0	73	100.0	200	100.0
Underwent Surgery	10	33.3	35	36.0	27	37.0	72	36.0
No Surgery[1]	20	66.7	62	64.0	46	63.0	128	64.0
Allowed Surgeon's Charges	$18,292		$32,600		$18,114		$69,006	
Average Allowed Surgeon's Charge	$ 1,829		$ 931		$ 671			
Estimated Avoided Surgeon's Charges for Beneficiaries Forgoing Surgery	$36,580		$57,722		$30,866		$125,168	
Allowable Charges for Second Opinions	$ 989		$ 3,705		$ 3,095		$ 7,789	
Ratio of Avoided Charges to Second Opinion Charges	37:1		16:1		$ 10:1		16:1	

Source: Beneficiary paid claims history data submitted by Connecticut General Life and Prudential Insurance, the carriers for Connecticut and New Jersey.

Footnotes:

1. Beneficiaries for whom there were no surgeon's, anesthesiologist's or other surgery related bills for the six months after they received a second opinion.

TABLE IV
SECOND OPINION
LOCAL REFERRAL SERVICE INQUIRIES
BY REGION
1981

	NUMBER	PERCENTAGE
U.S. Total	6,325	100.0%
Boston	298	4.7
New York	1,561	24.7
Philadelphia	1,737	27.5
Atlanta	711	11.2
Chicago	1,098	17.4
Dallas	144	2.3
Kansas City	65	1.0
Denver	81	1.3
San Francisco	534	8.4
Seattle	96	1.5

Source: HCFA, Office of Public Affairs

B. Cornell - New York Hospital and Massachusetts Experiences

1. General

Because of the impact of the factors discussed above, the constraints and limitations connected with the payment record data base (Appendix 1), and the limited number of carriers from which information could be obtained, the findings of this segment of the three-State study must be treated as rough approximations. To corroborate the findings and conclusions based on HCFA data sources, the second phase of the study entailed a review of the literature on the subject. We primarily focused on two studies which appeared to have relevance to the Medicare setting even though they dealt with populations not limited to Medicare beneficiares.

2. The Cornell - New York Hospital Experience [2]

This second opinion project has been in operation since 1972 and is the only one to have accumulated statistics on both voluntary and mandatory plans. The program's population consists of members and dependents of several Taft-Hartley health and welfare funds. The voluntary plan relies on individual initiative. It is estimated that only 2 to 5 percent participate, and those who do are usually facing major surgery. The mandatory plan provides no room for patient judgment. Roughly 85 percent of those recommended for surgery under the mandatory plan have a second opinion. In both plans, the final decision whether or not to have the recommended surgery rests with the individual.

The mechanics of the second opinion program are fairly straightforward. After receiving a recommendation for elective nonemergency surgery, the patient is scheduled for a second opinion consultation with a Board certified surgeon. The consultant either confirms or does not confirm the recommendation for surgery. Confirmation means he has no doubts that the surgery should be performed. Nonconfirmation shows that the consultant feels that surgery is not the most appropriate next step. He may feel that medical treatment and/or frequent checkups are preferable, or he may find no pathological justification for surgery. If the first opinion surgeon and the consultant do not agree, a third opinion tie-breaker is available. From February 1972 - April 1980, the program provided over 12,000 second opinions. For voluntary participants, about a third of the second opinions were nonconfirmations. The nonconfirmation rate of mandatory second opinions was about 18 percent. Combining the results yeilded an overall rate of 25 percent (2,968 out of a sample population of 11,878).

To measure how many individuals who got a second opinion decided to have/not have the surgery, a 2-year followup study was performed. Interviews conducted 6 months from the consultation showed that within both the voluntary and mandatory groups a large majority of individuals, who were not confirmed for surgery, did not undergo surgery (Appendix 2B). Interviews conducted 12 months after the consultation indicate that of those not confirmed for surgery in the voluntary group, 78.2 percent had not had the surgery performed. For the mandatory group the rate was 61.4 percent.

Over the course of the study, information gathered from participants indicates that the majority of those not confirmed for surgery decided not to undergo the surgery on the strength of the consultant's opinion (Appendix 2C).

Comparing medical utilization data of the confirmed and not confirmed groups in the mandatory program showed that the not confirmed group spent $361,756 less on medical care than the confirmed group. Total costs incurred by the program during the 2-year study period (1977-1978) were $203,300. The cost benefit ratio was 1.78, meaning for every dollar of cost incurred, $1.78 was saved. Since this analysis was based on per capita costs, it provides support for the conclusion that even if the cost of alternative treatment were taken into account, Medicare would have a positive cost benefit ratio in connection with the HHS second opinion program.

3. The Massachusetts Consultation Program for Elective Surgery [3]

Medicaid recipients without other health insurance coverage are required to participate in a second opinion program when proposed for one of eight selected procedures: hysterectomy, tonsillectomy and adenoidectomy, cholecystectomy, hemorrhoidectomy, disc surgery/spinal fusion, menisectomy, submucous resection/rhinoplasty (SMR), and excision of varicose veins. Emergency admittance for any of the eight procedures waives the mandatory participation requirement.

Two different modes of operation were used. First, there was a hands on model in which any patient not waived from the requirements was referred to a consultant for examination. The second was a desk audit model. In this model, a check list screening eliminated all cases where surgery was justified, and the balance were scheduled for consultations. Though coverage is contingent upon participation in the program, the decision whether or not to have the recommended surgery remained the recipient's.

Net savings statewide for the consultation program for elective surgery were estimated at $858,506 for the year following its implementation. The cost-savings ratio was 3.9. Savings for each health care foundation (the program's administrative unit) are presented in Table V. It reports information on gross savings, savings net of estimated substitution costs, program costs, savings net of program costs, and ratio of costs to savings net of substitution.

Other States have also adopted surgical preview programs. In January 1980, the Michigan Medical Program implemented a mandatory second opinion program for certain elective inpatient procedures. There too, the decision whether or not to undergo the surgery resided with the recipient. A similar program was instituted by the New Jersey Medicaid program on April 15, 1982.

TABLE V
SECOND OPINION SAVINGS
MASSACHUSETTS MEDICAID
BY HEALTH CARE FOUNDATION

	- Foundation -					
	Western	Central	Charles River	Bay State	Southeastern	Total
Gross Savings	$149,715	$126,072	$34,306	$659,090	$278,036	$1,247,219
Savings Net of Substitution Costs	138,910	117,358	31,390	609,315	255,332	1,152,305
Program Costs	50,595	56,346	16,519	122,401	47,938	293,799
Net Savings	88,315	61,012	14,871	486,914	207,394	858,506
Ratio of Costs to Savings Net of Substitution Costs	1:2.7	1:2.1	1:1.9	1:5.0	1:5.3	1:3.9

Source: The Effect of a Mandatory Second Opinion Program on Mediciad Surgery Rates - An Analysis of the Massachusetts Consultation Program for Elective Surgery, pg. 148.

V. RECOMMENDATIONS

The Department's experience and that of other voluntary and mandatory programs have demonstrated the cost effectiveness of second opinion programs both for the general population and for the Medicaid population.

RECOMMENDATION:

In view of the demonstrated positive results of second opinion programs, it is recommended that the voluntary second opinion effort be expanded and strengthened as a major tool for achieving program cost reductions. Expansion should include: (1) greater public information efforts to increase public awareness of the program and its benefits, (2) improved reporting requirements and systems, including a professional relations effort to encourage accurate reporting on Medicare bills, and (3) establishment of a focal point in HCFA with continuing full-time responsibility for expanding and improving the program and for measuring and reporting results, including development and oversight of subnational demonstrations and experiments.

RECOMMENDATION:

Priority should be given to modifying the voluntary second opinion and Medicare reimbursement regulations, at least on an experimental basis, to provide 100 percent reimbursement for second opinions to remove the economic disincentive of the deductible and coinsurance payments.

RECOMMENDATION:

Develop a mandatory second opinion program for Medicare (and for Medicaid at the States' option) to include the following characteristics:

(1) full payment of reasonable charges for surgery second opinion consultations;

(2) require second opinions for selected elective inpatient procedures for which there are high utilization rates or for which there is evidence of inappropriate or unnecessary surgery, and which may be deferred or avoided without risk or injury to the patient;

(3) specific procedures to be subject to mandatory second opinion program selected in consultation with the medical profession;

(4) voluntary second opinion program to remain in place for all other surgical procedures;

(5) permit full payment for third opinions where the consultant's findings do not agree with the first opinion surgeon; and

(6) allow beneficiary 6 months after consultation to reach decision on recommended surgery before again becoming subject to the mandatory second opinion program. After 6 months, conditions may have changed enough to warrant a reevaluation of the patient's condition.

APPENDIX 1
DATA SOURCES AND CONSTRAINTS

Several sources were employed in securing the data used in this report. Surgical and second opinion reimbursement data were secured from Part B bill payment records processed at HCFA's Bureau of Support Services. Dates are based on processing at HCFA and not tied in any way to the dates of service. Paid claims history data for individual beneficiaries who had received second opinions were supplied by the carriers for New Jersey, Connecticut and Pennsylvania. Published studies and HCFA statistical sources yielded information on various second opinion programs and national medical expenditures. General information sources included the 1980-1981 Source Book of Health Insurance Data and a variety of newspaper articles.

There are certain limitations and constraints associated with the data used in this report:

1. The published studies deal with groups that do not directly address themselves to the Medicare population. They cover Medicaid populations of young women and children, as well as trade union members and their dependents.

2. Part B bill payment record data are taken from all payment records received, accepted, and posted to beneficiaries' accounts at HCFA. A payment record is submitted for every bill for which reimbursement is made. The definition of a bill is a request for payment from a beneficiary accompanied by one or more itemized statements from a single physician or supplier. Though there may be more than one incident of service per payment record, only total reimbursement is reported. Frequencies are tallies of the number of payment records processed. Therefore, payment records can only provide estimates of Part B volumes and expenditures.

3. The number of second opinion consultations may be understated, few jurisdictions reported any significant second opinion activity. Part of this may be attributable to payment record coding errors. Surgery second opinions may be reported as regular physician visits or consultations. Due to computer problems and budgetary restraints, paid claims history data could only be secured from three carriers reporting any second opinion activity (Prudential Life Insurance (N.J.), Connecticut General Life (Conn.), and Pennsylvania Blue Shield (Pa.). Their cooperation is greatly appreciated.

4. The 1981 regional data contained in Table IV may be understating the number of inquiries to local second opinion referral services, as several regions have not kept up in their reporting activities. It is not known whether the referral services are inactive and/or not sending the data to the regions or whether the regional offices are being less than conscientious in reporting it.

When signed Return to L Schmidt 793 EHR

APPENDIX 2B

SURGICAL STATUS ANALYZED BY CONFIRMED/NOT CONFIRMED STATUS BY VOLUNTARY AND MANDATORY GROUPS
FEBRUARY 1972 - JUNE 1980

	VOLUNTARY				MANDATORY				TOTAL			
	Confirmed		Not Confirmed		Confirmed		Not Confirmed		Confirmed		Not Confirmed	
	N	%	N	%	N	%	N	%	N	%	N	%
FIRST FOLLOW-UP												
Surgery Performed	1018	70.3	242	17.2	929	85.8	329	32.5	1947	76.9	571	23.6
Surgery Not Performed	430	29.7	1168	82.8	154	14.2	683	67.5	584	23.1	1851	76.4
Total	1448	100.0	1410	100.0	1083	100.0	1012	100.0	2531	100.0	2422	100.0
SECOND FOLLOW-UP												
Surgery Performed	681	74.7	193	21.8	654	87.7	289	38.6	1335	80.5	482	29.5
Surgery Not Performed	231	25.3	692	78.2	92	12.3	460	61.4	323	19.5	1152	70.5
Total	912	100.0	885	100.0	746	100.0	749	100.0	1658	100.0	1634	100.0

Source: Finkel, M., et al. Eight Years' Experience With a Second Opinion Elective Surgery Program: Utilization and Economic Analyses., pp. 41 and 55.

APPENDIX 2A
CONFIRMED/NOT CONFIRMED STATUS OF STUDY POPULATION BY VOLUNTARY AND MANDATORY GROUPS FEBRUARY 1972 - APRIL 1980

	Voluntary		Mandatory		Total	
	N	%	N	%	N	%
Confirmed for Surgery	3,382	66.6	5,528	81.3	8,910	75.0
Not Confirmed for Surgery	1,697	33.4	1,271	18.7	2,968	25.0
Total	5,079	100.0	6,799	100.0	11,878	100.0

The sample size for both the voluntary and mandatory groups is sufficient to assert with 95 percent statistical confidence that the proportion of patients observed who are not confirmed for elective surgery is within 5 percent of the true proportion of such patients.

Source: Finkel, M., et. al. *Eight Years' Experience With a Second Opinion Elective Surgery Program: Utilization and Economic Analyses*., p. 27

APPENDIX 2B
SURGICAL STATUS ANALYZED BY CONFIRMED/NOT CONFIRMED STATUS
BY VOLUNTARY AND MANDATORY GROUPS
FEBRUARY 1972 - JUNE 1980

	VOLUNTARY				MANDATORY				TOTAL			
	Confirmed		Not Confirmed		Confirmed		Not Confirmed		Confirmed		Not Confirmed	
	N	%	N	%	N	%	N	%	N	%	N	%
FIRST FOLLOW-UP												
Surgery Performed	1018	70.3	242	17.2	929	85.8	329	32.5	1947	76.9	571	23.6
Surgery Not Performed	430	29.7	1168	82.8	154	14.2	683	67.5	584	23.1	1851	76.4
Total	1448	100.0	1410	100.0	1083	100.0	1012	100.0	2531	100.0	2422	100.0
SECOND FOLLOW-UP												
Surgery Performed	681	74.7	193	21.8	654	87.7	289	38.6	1335	80.5	482	29.5
Surgery Not Performed	231	25.3	692	78.2	92	12.3	460	61.4	323	19.5	1152	70.5
Total	912	100.0	885	100.0	746	100.0	749	100.0	1658	100.0	1634	100.0

Source: Finkel, M., et al. Eight Years' Experience With a Second Opinion Elective Surgery Program: Utilization and Economic Analyses., pp. 41 and 55.

APPENDIX 2C
INDIVIDUALS NOT CONFIRMED FOR SURGERY WHO HAVE NOT HAD SURGERY PERFORMED ANALYZED BY REASONS FOR HAVING NO SURGERY
FEBRUARY 1972 - JUNE 1980

	FIRST FOLLOW-UP						SECOND FOLLOW-UP					
	Voluntary		Mandatory		Total		Voluntary		Mandatory		Total	
REASONS	N	%	N	%	N	%	N	%	N	%	N	%
Surgery can be postponed (patient judgment)	69	6.6	72	10.9	141	8.3	31	5.9	41	10.3	72	7.8
Surgery too risky (patient judgment)	23	2.2	3	.5	26	1.5	6	1.1	4	1.0	10	1.1
Patient fears surgery	26	2.5	17	2.6	43	2.5	8	1.5	8	2.0	16	1.7
Symptoms disappear (patient judgment)	19	1.8	28	4.2	47	2.8	30	5.7	31	7.8	61	6.6
Condition tolerable	24	2.3	25	3.8	49	2.9	21	4.0	27	6.8	48	5.2
Followed advice of Consultant	861	82.9	498	75.3	1359	80.0	401	76.7	264	66.5	665	72.3
Followed advice of other Doctor	16	1.6	18	2.8	34	2.0	26	5.0	22	5.5	48	5.2
Total	1038	99.9	661	100.0	1699	100.0	523	99.9	397	99.9	920	99.9

Source: Finkel, M., et al. Eight Years' Experience With a Second Opinion Elective Surgery Program: Utilization and Economic Analyses., pp.45 and 62.

FOOTNOTES.

1. Physician -Induced Demand for Surgical Operations. Health Care Financing Administration, Office of Research, Demonstrations and Statistics, (March, 1981), p.31-33.

2. Finkel, M., et.al. Eight Year's Experience With a Second Opinion Elective Surgery Program: Utilization and Economic Analyses. Health Care Financing Administration, Office of Research, Demonstrations, and Statistics, (March 1981).

3. Martin, S.G., et.al. The Effect of a Mandatory Second Opinion Program on Medicaid Surgery Rates - An Analysis of the Massachusetts Consultation Program for Elective Surgery. Health Care Financing Administration, Office of Research, Demonstrations, and Statistics, (March 1980).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Memorandum

Date DEC 1 1982

From Director
Office of Research and Demonstrations

Subject Comments on Office of Inspector General Draft Report—A Mandatory Second Surgical Opinion Would Prove Beneficial to the Medicare and Medicaid Program

To Director
Office of Executive Secretariat

We welcome the opportunity to comment on this report. The Office of Research and Demonstrations (ORD) has been intimately involved with many of the issues raised in the report. During the last few years, ORD has sponsored a voluntary Medicare second surgical opinion program (SSOP) and the evaluation of this program, and a mandatory Medicaid SSOP in Massachusetts. The evaluation will be completed in September 1983.

There appears to be sufficient evidence that mandatory Medicaid SSOPs can substantially reduce the amount of surgery performed. This is supported by the findings from the Office of Research and Demonstration's evaluation of the Massachusetts mandatory SSOP. In addition, during the last two years, four additional States have adopted a mandatory Medicaid SSOP based on their independent assessment of program results in Massachusetts, Michigan and Wisconsin. While not an issue in these programs, the possibility exists in some States that mandatory SSOP programs might have a negative impact on physician participation rates in the Medicaid program, resulting in access problems for patients. Rather than putting forth legislation to require SSOPs for all Medicaid programs, HCFA and DHHS might want to encourage voluntary adoption of such programs by the States. For example, HCFA could agree to pay a larger proportion of the administrative costs of the SSOP program.

We also concur that voluntary Medicare SSOPs, because of their low use, will not generate a "sentinel effect" (i.e., physicians initially recommending fewer surgeries, resulting in declines in surgery rates over time). We agree that cost savings in mandatory second opinion programs result primarily from the sentinel effect, and not from the direct effect of program participants deciding to forego surgery.

Our comments on the OIG's recommendation that a legislative change be sought for "all Medicare beneficiaries to obtain second opinions for selected surgery as a condition for Medicare reimbursement" are as follows:

o The OIG uses cost savings achieved in three mandatory Medicaid SSOPs and extrapolates these findings to potential savings to the Medicare program. We find the OIG's extrapolation tenuous at best, and cannot support a national policy change based on this analysis. These estimates could be challenged on a number of technical grounds, including extrapolating the effects observed from a Medicaid to a Medicare population and basing cost savings on one State's experience. To date, we have no empirical evidence on mandatory SSOPs for Medicare beneficiaries.

- o The report does not estimate the administrative costs necessary to run a national mandatory Medicare SSOP, the costs associated with providing no-cost second opinions (we do concur that such second opinions, and in all probability, third opinions, must be at no cost to the beneficiary), or costs associated with informing beneficiaries that they will be required to obtain a second opinion for selected procedures. While we believe these costs, which would not be inconsequential, do not outweigh the potential benefits of a mandatory Medicare SSOP, we think the OIG should attempt to provide estimates of program costs in its final report.

- o The report does not consider the possible negative effects of mandatory second opinions on health outcomes. The OIG report assumes only "unnecessary surgery" would be eliminated by a mandatory Medicare SSOP, resulting in health benefits (e.g., avoidance of potential iatrogenic disease). However, the possibility exists that a mandatory Medicare SSOP could have a negative impact on health status. For example, foregoing needed cataract surgery or joint replacement may have a deleterious effect on elderly patients' well-being and costs to the Medicare program. We realize that no data presently exists to discuss this issue. ORD's analysis of the voluntary Medicare SSOP in New York and the Massachusetts mandatory SSOP will provide some information on this issue within the next six months.

- o The OIG report has not addressed the patients' rights issue raised by a mandatory SSOP in which the beneficiary does not have the opportunity to choose whether to participate. Nor has the report dealt with the issue of who would be at risk of nonreimbursement if a second opinion was not obtained--the patient or the physician?

- o The OIG, in its final report, should discuss issues of who would render the second opinion. Will special consultant panels be employed? If so, how would the panels be selected? Or alternatively, would any surgeon be eligible to provide a second opinion? Clearly, these and other possible alternatives might result in very different program outcomes. Will physicians be resistant to participating if they knew patients would be coming to them because they were required to do so?

In summary, we agree that there is good evidence that a mandatory SSOP could substantially reduce the amount of surgery performed, resulting in large potential cost savings. However, the detailed cost savings estimates made by the OIG report for a national mandatory Medicare SSOP are not well founded. In addition, the report fails to identify and suggest solutions for a number of key program implementation and operational issues. Based on the experience we have gained through our SSOP demonstration projects and their evaluation, we would welcome the opportunity to assist the OIG in the future development of a specific proposal.

Bryan R. Luce

Bryan R. Luce

DEPARTMENT OF HEALTH & HUMAN SERVICES

Memorandum

Date DEC - 2 1982

From Director
Health Standards and Quality Bureau

Subject Office of Inspector General Draft Report--A Mandatory Second Surgical Opinion Would Prove Beneficial to the Medicaid and Medicare Programs

To John Spiegel, Director
Office of Executive Secretariat
Attn: Linda Schmidt
Audit Liaison Staff

We agree with program efforts to reduce the number of elective surgeries reimbursed by Medicare and Medicaid but disagree with the implementation of a Mandatory Second Opinion Program at this time. We feel there are several issues that should be explored by the Inspector General before making the recommendation that the Health Care Financing Administration (HCFA) should seek legislation to adopt a mandatory Second Surgical Opinion Program (SSOP) for the Medicaid and Medicare programs.

First, there are several technical medical issues which are left unanswered in the draft report and which may require further exploration.

- The rates of 10 elective surgical procedures have decreased in three States having mandatory SSOPs. However, the question arises of whether there has been a shift from performing these elective surgical procedures to performing other, related procedures. For example, while prostatectomies employing the transurethral approach (i.e., TURPs - Transurethral Resection of the Prostate) have been reduced, what has happened to the suprapubic, retropubic and perineal approach to performing prostatectomies? These are three other approaches for surgically treating benign prostatic hypertrophy and are not among the procedures for which second surgical opinions were required in the States studied.

- Second surgical opinion programs will deal, in general, only with elective surgical procedures. It would therefore be important to know whether a mandatory SSOP will cause a shift from performing elective procedures to performing so-called emergency surgical procedures of the same type. For example, an "elective" cholecystectomy could rather easily be called an "emergency" cholecystectomy based on the signs or symptoms which the patient has. Will the SSOP proposed for Medicare and Medicaid beneficiaries and recipients be restricted to only "elective" procedures of a given type or will both elective and emergency procedures of a given type be included in the mandatory SSOP?

There are several other issues to be addressed with regard to the Inspector General's draft report.

- o How representative of the nation are the three States (Massachusetts, Wisconsin and Michigan) upon which the report is based? It seems imperative that this issue be explored.

- o It is important for the Inspector General to review carefully and re-evaluate the raw data from the three States having mandatory SSOPs in order to corroborate the findings of the States. We are concerned that the analysis is superficial and may be providing an inaccurate picture.

do independent analysis of Wisconsin and Michigan

modify Abt contract

& also — feasibility of Medicare program —

- o The report leads one to assume that no study has been done in the States having mandatory programs to ascertain if surgeries performed after the second opinion were medically necessary. At the outset, the beneficiary, physician, and provider community would need to be told that this mandatory program does not replace binding medical necessity review either by the PSRO/PRO or carrier.

- o The issue of beneficiary "knowledge" under waiver of liability becomes murky if the second physician indicates to the beneficiary that the proposed procedure is, in his opinion, not medically necessary. It would appear that the only fair thing to do in these cases is declare that the beneficiary would not be prepared to have clear cut "knowledge" and would have his claim handled as any other beneficiary's claim would be handled.

- o The data does not provide any evidence that cost savings recorded by State Medicaid agency demonstrations were lasting. For example, the symptoms which require surgery of the prostate, gallbladder, joints, etc. could have been treated conservatively to alleviate the symptoms temporarily, and the surgery could have been performed a year or two later. Worse, the delay in receiving surgery could result in palliative or other health care costs that over time exceed the cost of the procedure. These costs are rarely or accurately calculated by these studies. If such a program were instituted, the cost savings projected would probably be offset slightly by the cost of additional diagnostic studies that might be required by the second physician. We believe a longitudinal study encompassing

Page 3 - John Spiegel, Director, OES

5 year study → get Prudential [illegible] [illegible], also BCBS-MN — competitive environment.

a minimum of five years is necessary to determine authentic cost savings. Such a study should also include direct patient sampling to determine the satisfaction of the beneficiaries and the impact on overall quality of care.

If you have any questions about our comments, please contact Kay Terry, Director, Office of Policy Development and Coordination. She can be reached at 594-5033.

Thomas D. Hoyer for
Philip Nathanson

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Memorandum

Date DEC - 2 1982

Refer To: FQA-421

From Director
Office of Coverage Policy
Bureau of Program Policy

Subject Office of Inspector General Draft Report—A Mandatory Second Surgical Opinion Would Prove Beneficial to the Medicaid and Medicare Programs (ACN 03-31211) (Your Memorandum dated 11-18-82)—ACTION

To Director
Office of Executive Secretariat

We have reviewed the subject draft report and have the following comments to offer on its findings and recommendation that HCFA should seek legislation mandating second surgical opinions under the Medicare and Medicaid programs for certain elective surgical procedures. The proposed legislation would include waiver of all deductible and coinsurance requirements for Medicare beneficiaries seeking second opinions. However, the final decision on whether or not the operation should take place would remain with the beneficiary regardless of the judgment of the first or second opinion physician.

General

Based on information we have reviewed on the mandatory second surgical opinion programs (SSOPs) that have been implemented in the United States , we agree with the Inspector General (IG) that these programs appear to be more cost-effective than the voluntary SSOPs that have been studied. However, experience with the mandatory SSOPs in both the public and private sectors has been so very limited that we believe it would be premature to seek legislation in this area without further analysis and evaluation of these programs. Information is especially limited with respect to the impact of mandatory SSOPs upon Medicare beneficiaries because present law precludes the application of this type of program by Medicare contractors.

To expand HCFA's understanding of the effects of mandatory SSOP programs we recommend that the Office of Research and Demonstrations take the lead in (1) evaluating more thoroughly the mandatory State Medicaid SSOPs that have been implemented in Massachusetts, Michigan, Wisconsin and other States and (2) conducting Medicare demonstration projects testing the mandatory concept. These studies should include an analysis of different aspects of these mandatory programs such as (1) their administrative cost, (2) their long-term impact on Medicare and Medicaid benefit payments (i.e., it would be useful to include up to at least 36 to 48 months of experience with each program), (3) the cost of waiving all of the Medicare deductible and coinsurance requirements for beneficiaries who obtain second opinions, (4) their effect upon participating patient's health outcomes and (5) their impact upon the medical community and the physician-patient relationship. If it is concluded that the mandatory concept is cost-effective and politically feasible to implement nationally, it would also be useful to know how best to do this. For example, one question might be whether the second opinion physician should meet minimum qualifications with respect to training and experience. We believe this additional information should give HCFA a much better basis for deciding whether it would be cost-effective and politically feasible to seek legislation in this area and, if so, what that legislation might be.

Voluntary SSOPs Had Little Impact on Elective Surgeries (Pages 2 and 3)

We agree with the IG's finding that voluntary SSOPs appear to have had little impact upon reducing the number of elective surgeries that have been performed under the Medicare and Medicaid programs. The basic reason for this, as shown by the two Medicare SSOP demonstration projects that HCFA has conducted, is that beneficiaries appear to have little interest in participating in these programs. Participation in the Medicare demonstration SSOPs ranged from one to two percent of those eligible beneficiaries considering surgery which is lower than the participation experienced in other voluntary programs. This was the case even though extensive publicity efforts were used to make beneficiaries aware that they would incur no direct out-of-pocket costs for obtaining a second opinion because HCFA agreed to pay the Medicare deductible and coinsurance requirements.

We believe an important reason that Medicare beneficiaries do not obtain second opinions is because they are unwilling to "second-guess" the first opinion physician. This experience with Medicare beneficiaries in voluntary SSOPs needs to be kept in mind in examining the merits of proposed Medicare mandatory SSOPs because reluctance of many beneficiaries to spend the time to see a second physician after they have been examined by the first physician together with resistance to the mandatory program from within the medical community itself could seriously jeopardize any national effort in this area.

Mandatory SSOPs Have Proven Successful (Page 3)

We agree that the Medicaid mandatory SSOPs that have been started in the past few years show considerable promise for reducing the number of surgeries paid for in their respective States. However, we believe it is much to early to conclude that the three mandatory programs specifically cited by the IG as having significantly reduced the Medicaid surgery rates in their States have been proven to be successful. Although the Massachusetts mandatory program has been in operation since 1977 none of the other State programs have have been in effect for longer than about one or two years which is too short a time to reach any firm conclusions.

Michigan had submitted - grant applicat

HCFA has contracted with the ABT Associates, Inc., to evaluate the mandatory Massachusetts SSOP experience and the results of this evaluation should be helpful in assessing just how successful that program has been and whether its projected cost-savings are going to be realized in the long run. We believe the same type of long-run analysis of other State mandatory programs needs to be done as well. For example, previous studies of SSOPs have demonstrated that rather than simply reducing the surgery rate for the patients' being evaluated, these programs often just prompt the patient to postpone the surgery until a later date or they result in the use of an alternative course of treatment for the patient that may cost more in the long-run than the cost of the surgery that was avoided. Other important long term considerations include the effect that the mandatory SSOP programs have on the patients' final health outcome and quality of life and the reaction to these programs within the Medicare and Medicaid populations and the professional medical community. We believe it is critical that we learn about the long-run effects of these mandatory SSOPs (i.e., up to 36 to 48 months of experience with these programs) before we consider requiring them on a national basis.

National Impact of Mandatory SSOP Would be Significant for Both Medicaid and Medicare (Pages 3, 4, and 5)

The IG's report states on page 3 that "studies on SSOPs have pointed out two irrefutable facts (emphasis added) and the second of these two facts is that "mandatory SSOPs lead to a substantial reduction in the number of elective surgeries and are cost-effective." As indicated above in our discussion of the previous item, there is insufficient data to reach this conclusion with respect to the Medicare and Medicaid programs, but especially with respect to the Medicare program because we have had no experience with mandatory SSOPs under that program.

The IG's report on pages 4 and 5 goes on to estimate that the application of mandatory SSOPs on a national basis will reduce elective surgery by as much as 29 percent under Medicaid and 28.5 percent under Medicare, at annual cost savings of about $63 million and $179 million, respectively. We do not believe that the IG's national estimates of the impact of mandatory SSOPs upon the Medicare and Medicaid program are based on valid assumptions or sound calculation methodology. Rather, at best they appear to be very speculative projections based on limited results obtained from three State Medicaid populations that are not necessarily representative of the national Medicaid or the national Medicare populations. For example, the three Medicaid States cited by the IG are Massachusetts, Michigan and Wisconsin which are three northern States that may not have much in common with the other States in terms of the population characteristics and health care utilization of their Medicaid populations. In addition, the Medicare beneficiaries generally are a much older, less mobile population group than the Medicaid population, with different (and more complicated) illnesses and diseases and with higher surgical utilization rates, all of which may affect the impact of the mandatory SSOPs upon surgery rates and of course upon any net cost savings that might be realized.

Good point

Another problem that should be mentioned is that a national uniform mandatory SSOP program for certain specific surgical procedures may not be cost-effective because of the variation of surgical rates by regions (and even localities) for different surgical procedures. Finally, there could be an administrative problem with mandatory SSOPs because of limited access of patients in rural areas to qualified physicians who can provide second opinions.

We appreciate having the opportunity to comment on the subject draft report. If you have any questions about our comments, please direct them to William Larson on extension 49374.

for Robert A. Streimer

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Memorandum

Date DEC 9 1982

From Carol A. Kelly CAK
Deputy Director
Office of Legislation and Policy

Subject Office of Inspector General Draft Report - A Mandatory Second Surgical Opinion Would Prove Beneficial to the Medicaid and Medicare Programs

To John Spiegel
Director
Office of Executive Secretariat

We have reviewed the Inspector General's draft report which recommends a mandatory second surgical opinion program for Medicare and Medicaid. We do not believe that the draft report is a balanced treatment of the subject. Thus, we are skeptical about the recommendation for the following reasons.

The savings estimates are unsupportable. Few details are presented on how the costs savings were estimated. Areas of concern include:

— No mention is made about the generalization of Medicaid results to Medicare. Because of different populations such generalizations are not necessarily appropriate.

— No mention is made of the appropriateness of generalizing from a small sample — three states. These three states may have had atypical rates of surgery in the study period.

— The validity of the methodologies of the studies of the three Medicaid programs is not discussed. For example, the reduction in surgery in the three Medicaid programs is reported for a particular point in time with all the results attributed to the second opinion program. No mention is made of whether or not there had been a secular decline in surgery prior to and independent from the second opinion program. Moreover, two of the three Medicaid programs did not have independent evaluations.

— Savings are not separately identified between non-confirmations vs. the sentinel effect (i.e., fewer recommendations for surgery because of the second opinion program). This is important because the report indicates that the bulk of the savings come from the sentinel effect. If that effect can be circumvented through a learning process whereby physicians find which of their colleagues will confirm their primary opinion, then the bulk of the savings could be lost.

— A number of costs appear to be excluded. For example, no costs are included to administer the second opinion program and to inform beneficiaries of the need for second opinions. It appears that the cost of the second opinion itself is omitted, as well as the waiver of cost-sharing for the second opinion. Potential costs of "third opinions" are excluded.

— No mention is made of the experience of second opinion programs in the private sector. This is a significant omission since at least one large private insuror (Blue Cross and Blue Shield of Greater New York) found that second opinions for selected procedures increased costs rather than decreasing them. The increase occurred because the second opinion reinforced the primary surgeon's recommendation and made patients more likely to have surgery. Some surgery would not have occurred based on the primary surgeon's recommendation only.

— No justification is provided for use of a number of assumptions used in the table calculating Medicare cost savings. For example, no justification is provided for use of Wisconsin Medicaid average costs per procedure in estimating savings. Why are the figures from one state representative of the nation? The use of data only from the Northeastern and Southern regions is not justified. There is no specification of how the "avoided operatons" were calculated. Different percentage reductions were assumed for different operations without explanation.

actuarial estimate

For these reasons, the savings from a mandatory second opinion program appear exaggerated. An actuarial estimate is needed. It may be that there are costs, not savings, from a mandatory second opinion program.

Other concerns with the report and recommendations include:

— There is no discussion of the potential adverse effects of a mandatory program on health outcomes and the quality of care.

— The issue of who does the second opinion is avoided. Is a physician of the same specialty as the primary physician acceptable or must the physician be of another specialty?

— The compulsory requirement for a service in an entitlement program has implications for beneficiary freedom of choice which are not discussed.

— The issue of emergency situations is not addressed. What happens if a patient has an emergency need for one the selected operations? Will it be reimbursed?

For these reasons, we are very skeptical about now recommending a legislative proposal for mandatory second opinions for Medicare and Medicaid. We believe that considerable further analysis of these and other issues and development of actuarial cost estimates is needed.

2 8 JAN 1983

Carolyne K. Davis, Ph.D. Carolyne K. Davis
Administrator
Health Care Financing Administration

Office of the Inspector General Draft Report — A Mandatory Second Surgical Opinion Would Prove Beneficial to the Medicaid and Medicare Programs - ACN 03-31211

The Inspector General
Office of the Secretary

We have reviewed the draft report which recommends a mandatory second surgical opinion program for Medicaid and Medicare. Based on information we have reviewed on the mandatory second surgical opinion programs (SSOPs) that have been implemented in the United States, we agree with the Inspector General (IG) that these programs appear to be more cost-effective than the voluntary SSOPs that have been studied. However, experience with the mandatory SSOPs in both the public and private sectors has been so very limited that we believe it would be premature to seek legislation in this area without further analysis and evaluation of these programs. Information is especially limited with respect to the impact of mandatory SSOPs upon Medicare beneficiaries because present law precludes the application of this type of program by Medicare contractors.

Several years ago, the Department supported legislation that would provide the Secretary with the authority to enter into contracts for demonstration projects to determine the cost effectiveness and appropriateness of requiring a second opinion for specified elective surgical procedures as a condition for payment under either Medicare or Medicaid. After considerable congressional debate which focused on many of the generic issues discussed in this memorandum, this proposal was not enacted.

HCFA continues to vigorously support the voluntary SSOP. Since 1979 we have distributed 9 million copies of the SSOP brochure. We receive on the average of 50 letters per day requesting additional information and the Hotline averages 1,000 inquires per month. We have submitted information on the SSOP to 10 major magazines and seven insurance companies who are anticipating promoting the program. HCFA's Office of Public Affairs has done five radio talk shows and recently produced and distributed two public service television spots featuring Betty White.

We believe the subject report does not contain sufficient analysis to document the cost savings estimated. Our areas of concern include:

- No mention is made about the generalization of Medicaid results to Medicare. Such generalizations are not necessarily appropriate because the Medicare beneficiaries are a much older, less mobile population group than the Medicaid population, with different (and more complicated) illnesses and diseases and with higher surgical utilization rates. This may effect the impact of mandatory SSOPs upon surgery rates and of course upon any net cost savings that might be realized.

- No mention is made of the appropriateness of generalizing from a small sample. The three Medicaid States cited in the report (Massachusetts, Michigan and Wisconsin) are northern States and may not be representative of the country in terms of population and health care utilization.

- The validity of the methodologies of the studies of the three Medicaid programs is not discussed. For example, the reduction in surgery in the three Medicaid programs is reported for a particular point in time with all the results attributed to the second opinion program. No mention is made of whether or not there had been a secular decline in surgery prior to and independent from the second opinion program. Moreover, two of the three Medicaid programs did not have independent evaluations.

- Savings are not separately identified between non-confirmations vs. the sentinel effect (i.e., fewer recommendations for surgery because of the second opinion program). This is important because the report indicates that the bulk of the savings come from the sentinel effect. If that effect can be circumvented through a learning process whereby physicians find which of their colleagues will confirm their primary opinion, then the bulk of the savings could be lost.

- A number of costs appear to be excluded. For example, no costs are included to administer the second opinion program and to inform beneficiaries of the need for second opinions. It appears that the cost of the second opinion itself is omitted, as well as the waiver of cost-sharing for the second opinion. Potential costs of "third opinions" are excluded.

- No mention is made of the experience of second opinion programs in the private sector. This is a significant omission since at least one large private insuror (Blue Cross and Blue Shield of Greater New York) found that second opinions for selected procedures increased costs rather than decreasing them. The increase occurred because the second opinion reinforced the primary surgeon's recommendation and made patients more likely to have surgery. Some surgery would not have occurred based on the primary surgeon's recommendation only.

- No justification is provided for use of a number of assumptions used in the table calculating Medicare cost savings. For example, no justification is provided for use of Wisconsin Medicaid average costs per procedure in estimating savings. Why are the figures from one State representative of the nation? The use of data only from the Northeastern and Southern regions is not justified. There is no specification of how the "avoided operations" were calculated. Different percentage reductions were assumed for different operations without explanation.

There are several technical medical issues which are left unanswered in the draft report and require further exploration.

- The report does not consider the possible negative effects of mandatory second opinions on health outcomes. The report assumes only "unnecessary surgery" would be eliminated by a mandatory Medicare SSOP, resulting in health benefits (e.g., avoidance of potential iatrogenic disease). However, the possibility exists that a mandatory Medicare SSOP could have a negative impact on health status. For example, foregoing needed cataract surgery or joint replacement may have a deleterious effect on elderly patients' well-being and costs to the Medicare program. We realize that no data presently exist to discuss this issue. HCFA's analysis of the voluntary Medicare SSOP in New York will provide some information on this issue within the next six months. HCFA has contracted with ABT Associates, Inc., to evaluate the mandatory Massachusetts SSOP experience and the results of this evaluation should be helpful in assessing just how successful that program has been and whether its projected cost-savings are going to be realized in the long run. The evaluation will be completed in September 1983.

- The rates of 10 elective surgical procedures have decreased in three States having mandatory SSOPs. However, the question arises of whether there has been a shift from performing these elective surgical procedures to performing other, related procedures. For example, while prostatectomies employing the transurethral approach (i.e., TURPs - Transurethral Resection of the Prostate) have been reduced, what has happened to the suprapubic, retropubic and perineal approach to performing prostatectomies? These are three alternative approaches for surgically treating benign prostatic hypertrophy and are not among the procedures for which second surgical opinions were required in the States studied.

- Second surgical opinion programs will deal, in general, only with elective surgical procedures. It would therefore be important to know whether a mandatory SSOP will cause a shift from performing elective procedures to performing so-called emergency surgical procedures of the same type.

  For example, an "elective" cholecystectomy could rather easily be called an "emergency" cholecystectomy based on the signs or symptoms which the patient has. Will the SSOP proposed for Medicare and Medicaid beneficiaries and recipients be restricted to only "elective" procedures of a given type or will both elective and emergency procedures of a given type be included in the mandatory SSOP?

- The issue of emergency situations is not addressed. What happens if a patient has an emergency need for one of the selected operations. Will it be reimbursed?

- The issue of who renders the second opinion is avoided. Will special consultant panels be employed? If so, how would the panels be selected? Or alternatively, would any surgeon be eligible to provide a second opinion? Clearly, these and other possible alternatives might result in very different program outcomes. Will physicians be resistant to participating if they knew patients would be coming to them because they were required to do so?

In addition to the cost savings and technical medical issues in the report, there are several operational concerns that should be addressed.

- The compulsory requirement for a service in an entitlement program has implications for beneficiary freedom of choice.

- If a beneficiary does not have a second opinion, who is at risk? Can the surgeon or the hospital be held just as liable as the beneficiary?

- In Massachusetts, if the second opinion differed from the first, a Medicaid beneficiary had to have a third consultation. Are States going to be allowed to enforce a third opinion?

In summary, we believe it is critical that we learn about the long-run effects of these mandatory SSOPs (at least 36 to 48 months of experience with these programs) before we consider implementing them on a national basis.

If you have any questions, please contact Linda Schmidt of the Audit Liaison Staff on FTS 934-7491.

OEC:ALS:LSchmidt:mpc 12/16/82 (TL ACN-31211 D. 7-9)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

ALS/OEO:ACTION
cc:Odachowski/Davis
Odachowski/Bouroue
KButo, DRidlev, AAP
AAO, AAM, AAEA, OLP
OIA, OPA, BERC, Spiegel
Broglie, JGreene
DUE:4/15 NOR:Adm. Sig.

MAR 22 1983

NOTE TO CAROLYNE DAVIS

Attached is a copy of our final report on second surgical opinion programs (03-30211) for your information and review.

As discussed by my letter formally transmitting this report to you (bound in report) we found that the impact of:

--voluntary programs is minimal, while that of
--mandatory programs is most substantial.

HCFA's reaction to our recommendations calling for legislative action now for mandatory second surgical opinion programs was negative. Lengthy further study was said to be needed.

We have since reassessed our findings and conclusions and continue to believe that such mandatory programs are most practical, cost-effective, and of real benefit to Medicare/Medicaid recipients. Since we consider mandatory programs worthy of current implementation, I plan to make distribution of our report to the Governors and Medicaid directors of those States which have not yet implemented mandatory programs. This action is in accord with our policy of disseminating information on "best practices" to interested parties. Our report is also being sent to the Secretary, and she is being informed about the further distribution planned.

Richard P. Kusserow
Inspector General

Attachment

MAR 22 1983

/s/ Richard P. Kusserow

Richard P. Kusserow
Inspector General

OIG Audit Report "A Mandatory Second Surgical Opinion Program Would Prove Beneficial To The Medicaid and Medicare Programs" --INFORMATION

The Secretary
Thru: US ____
ES ____

Purpose: This memorandum discusses a report I released today to HCFA Administrator Davis on the results of our review of Second Surgical Opinion programs. Such programs are intended to encourage individuals to voluntarily seek second opinions before undergoing elective surgery. We found that the impact of:

--voluntary programs is minimal, while that of
--mandatory programs is most substantial.

HCFA's reaction to our recommendations calling for legislative action now for mandatory second surgical opinion programs was negative. Lengthy further study was said to be needed.

This memorandum will give you an overview of the program . . . the findings and recommendations resulting from our review, and . . . information concerning HCFA's actions regarding this program.

I might add that this audit has been ongoing for quite some time and that the press has become aware of it. For this reason the final report may well receive press attention. Also, Tony Dolan of the White House Press Office has requested a copy of the report upon its release. We understand that he may include this subject and report in future Presidential speeches.

FACTS

Background: In January 1976, the Subcommittee on Oversight and Investigations of the House Committee on Interstate and Foreign Commerce reported that an estimated 2.4 million unnecessary surgeries were performed in 1974 at a waste of 11,900 lives and about $4 billion. The report called on

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SEC

the then HEW to begin a program of independent second professional opinions to confirm the need for elective surgery underwritten by Medicare and Medicaid. Such a program was begun in 1974 under HCFA auspices; it included national public service announcements, the opening of referral centers and so on. Two Medicare carriers were awarded 3-year demonstration contracts to test whether waiving co-payment and deductible would encourage Medicare beneficiaries to seek second opinions. Other carriers were instructed to pay 80 percent of reasonable charges for such second opinions. Most State agencies agreed to pay for voluntary second opinions with respect to Medicaid.

Program Results

o Most States (Medicaid) and the majority of Blue Shield plans (Medicare) offer some type of program, most of which are voluntary.

o HCFA reported to the Congress (March 1982) that there was a maximum reduction of 12 percent in elective surgery for participants in the two demonstration projects.

o Individuals generally do not voluntarily seek second surgical opinions--HCFA's report to the Congress commented on how few people choose to use them (New York 1.2 percent utilization; Michigan 6.3 percent).

o A report by the National Governors' Association concluded that there was about two percent utilization.

o On the other hand, mandatory programs have been proven successful. Seven States have mandatory programs, three of these have been in being for enough time to judge impact (Massachusetts, Michigan and Wisconsin). These States focused their programs on up to ten selected surgical procedures which they felt had the highest incidence of inappropriate surgery. Massachusetts reports cost savings at more than $1 million annually; Michigan at $3.7 million; and Wisconsin at a total of $2.8 ($1.8 Medicaid, $1 million Medicare).

The Sentinel Effect: This is an interesting phenomenon reported from several sources with respect to mandatory programs. Essentially it means that physicians initially recommend few surgeries because they are aware their decisions to operate will be reviewed by other physicians. (Massachusetts and Wisconsin have reported that 70 to 90 percent of their savings were due to the sentinel effect.) HCFA, in reporting on its voluntary programs, stated "it seems unlikely that a significant sentinel effect would exist, since utilization of these programs is extremely low."

Savings If Implemented Nationally: While we did not attempt to explore the factor of saving lives through avoidance of unnecessary surgery as the Congress did, we do have projections on probable cost savings if mandatory plans were implemented on a national basis: some $63 million annually for Medicaid and $94.7 million for Medicare. (The bases for these projections are given on pages 6 and 7 of our report.)

HCFA Reaction: HCFA's reaction to our recommendations calling for legislative action now for mandatory second surgical opinion programs was negative. Their response which is incorporated in our report states that lengthy further study was needed. In this regard, my letter transmitting this report to Administrator Davis pointed out that HCFA has already spent over $2.5 million to evaluate these programs. To us additional studies will not add anything substantial to what is already known.

Since we consider mandatory programs worthy of current implementation, I plan to make distribution of our report to the Governors and Medicaid directors of those States which have not yet implemented mandatory programs. This action is in accord with our policy of disseminating information on "best practices" to interested parties.

Attachment

Tab A - OIG Audit Report
Distribution
Carolyne K. Davis, Ph.D., Administrator, HCFA
Dale Sopper, Assistant Secretary for Management and
  Budget (w/copy of report)
Prepared by: OIG:Office of Audit:FJMajka-472-3155
Contact: OIG:Office of Audit:FJMajka-472-3155

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

MAR 22 1983

Carolyne K. Davis, Ph.D.
Administrator, Health Care Financing
  Administration
Department of Health and Human Services
Washington, D. C. 20201

Dear Dr. Davis:

The enclosed report concerns the effectiveness of Second Surgical Opinion Programs (SSOPs) in reducing elective surgeries reimbursed under Medicare and Medicaid. It shows that voluntary SSOPs have sprung up all over the country due, in large part, to HCFA's promotion and support. Unfortunately these SSOPs have not had a significant impact on Medicare and Medicaid largely because individuals simply do not voluntarily seek second opinions. Conversely, mandatory SSOPs have proven to be very effective in terms of reducing the number of elective surgeries performed and the overall cost of medical care. We estimate that a potential exists for achieving savings exceeding $157 million annually if a mandatory SSOP is incorporated into the Medicare and Medicaid programs.

Officials of your office did not agree that action should be taken now to incorporate a mandatory SSOP in either program. One reason given was the limited experience with mandatory SSOPs particularly with respect to their impact upon Medicare beneficiaries. You stated that at least 3 to 4 years of experience with mandatory programs is necessary before you can consider implementing them on a national basis.

You are aware, I am sure, that HCFA has already spent over $2.5 million to evaluate SSOPs. The data generated from these evaluations as well as other studies lead me to conclude that mandatory SSOPs are far more effective than voluntary programs. Additional studies, in my opinion, will not add anything substantial to what is already known about SSOPs. Nor will these studies provide more insight on the impact of mandatory SSOPs on Medicare beneficiaries because of the current law which prohibits such programs. I am convinced that further delay in implementing a mandatory SSOP can only result in more unnecessary surgeries being performed and more health care funds wasted. Therefore, I recommend that this matter be included in the Department's 1985 legislative proposal.

I would appreciate receiving your comments on this matter by April 22, 1983.

Sincerely yours,

Richard P. Kusserow
Inspector General

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INTRODUCTION

This report summarizes the results of our review of Second Surgical Opinion Programs (SSOPs) and their impact on Medicaid and Medicare. Our review was performed primarily to determine whether SSOPs were effective in reducing the number of elective surgeries -- non-emergency surgeries that can be postponed or avoided without undue risk to the patient -- reimbursed by Medicaid and Medicare and, if not, what actions could be taken by the Health Care Financing Administration (HCFA) to improve their effectiveness. In reviewing the SSOPs, we queried Medicaid officials in all 50 states; examined operational reports prepared by three State Medicaid Agencies; discussed SSOP participation with Medicare carriers; and reviewed the results of two Medicare demonstration projects and other SSOP studies.

Our review showed that voluntary SSOPs have not had a significant impact on the number of elective surgeries performed under the Medicaid and Medicare programs because recipients under both programs generally did not voluntarily seek second opinions. Conversely, the few mandated SSOPs operated by State Medicaid Agencies and a private insurer clearly demonstrated that they were effective in reducing both the volume of elective surgeries and the costs associated with them. We estimate that a mandatory SSOP applied nationally could reduce elective surgery by as much as 29 percent in Medicaid and 18 percent in Medicare at annual cost savings of about $63 million and $94.7 million, respectively.

Background

In January 1976, the Subcommittee on Oversight and Investigations of the House Committee on Interstate and Foreign Commerce reported that an estimated 2.4 million unnecessary surgeries were performed in 1974 at a waste of 11,900 lives and about $4 billion.[1] The report recommended that the then Department of Health, Education and Welfare promptly institute a program of independent second professional opinions to confirm the need for elective surgery underwritten by Medicare and Medicaid. Such a program would, according to the Subcommittee, save the Government millions of dollars.

In an effort to comply with Congress' mandate, HCFA initiated a National Second Opinion Program in 1977 to encourage all Americans to voluntarily seek a second opinion before undergoing elective surgery. A huge kick-off campaign, including national public service announcements, national distribution of brochures, the establishment of a national hot-line and the opening of referral centers heralded the start of the program. Its primary objective was to decrease the amount of inappropriate surgery performed, thereby avoiding the costs and risks of surgery without jeopardizing the health and well-being of the patient. The national program also was intended to influence patients' behavior by encouraging them to be more informed and involved in decisions on their health care.

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[1] U.S. Congress, House of Representatives. Cost and Quality of Health Care: Unnecessary Surgery. 94th Congress, 1976.

As part of the overall campaign, HCFA, in September 1977, awarded demonstration contracts to Blue Cross and Blue Shield of Michigan and Blue Cross and Blue Shield of New York. The demonstration projects, which were to last for three years at a cost of about $1 million, were to test whether a financial incentive -- waiver of the co-payment and deductible -- would encourage Medicare beneficiaries to voluntarily seek a second opinion. Other Medicare carriers were instructed to pay 80 percent of reasonable charges for beneficiaries who voluntarily sought second opinions. With regard to Medicaid, most State Agencies agreed to pay for voluntary second opinions.

DISCUSSION OF FINDINGS

Voluntary SSOPs Had Little Impact On Elective Surgeries

Due in large part to HCFA's efforts, SSOPs have sprung up all over the country. Almost every State Medicaid program and about 50 to 70 percent of all Blue Shield Plans offer some type of SSOP, the majority of which are voluntary. These programs encourage individuals to obtain second opinions at no cost to themselves, but it is ultimately the individual who chooses whether or not to participate. Voluntary programs do have an effect on the decision to have surgery when these programs are utilized and, therefore, can result in reduced costs. For example, a HCFA report [2] submitted to Congress on March 25, 1982, attributed a maximum reduction of 12 percent in elective surgeries for participants in the two demonstration projects. Also, a large private insurer reported that the average net reduction in medical expenses per each avoided surgery was $2,600.

The problem that exists with voluntary SSOPs -- and the principal reason they have not had a significant impact on the number of elective surgeries -- is the simple fact that individuals generally do not voluntarily seek second opinions. The HCFA report to Congress concluded that "the most striking fact regarding all voluntary SSOPs is that few people choose to use them". For example, in the New York project, only 1,763 of the 142,000 (1.2 percent) recipients who underwent surgery obtained second opinions. The utilization rate was even lower in Michigan where only 116 of the 44,000 (0.3 percent) recipients who were operated on obtained second opinions.

These statistics are basically consistent with conclusions included in a report [3] published by the National Governors' Association. The report concluded that usually only two percent of the potential recipients take advantage of voluntary programs, and there is some evidence that this may even overestimate the true participation rate. According to the report, two factors are frequently offered to explain these low participation rates. One explanation is that many individuals are simply unaware of the availability of the second opinion benefit. The other explanation is that patients do not obtain second opinions apparently because they fear they will insult their physician by questioning his/her decision. The validity of the latter explanation is borne out to a large degree by HCFA's two demonstration projects. In New York, 76 percent of the participants requested that the referral center not contact the first opinion surgeon. In Michigan, 52 percent of the participants chose confidentiality.

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[2] Department of Health and Human Services, Report on Medicare Second Surgical Opinion Programs: The Effect of Waiving Cost-Sharing. March 25, 1982.

[3] State Medicaid Information Center, Center for Policy Research, National Governors' Association, Controlling Medicaid Costs: Second Surgical Opinion Programs. November 1982.

We contacted all the State Medicaid Agencies that sponsored voluntary SSOPs and two Medicare carriers to determine whether the low participation rates mentioned above were typical of the Medicaid and Medicare population in general. Those contacted had no specific data on the extent of recipient participation or the effectiveness of the voluntary programs. There is no reason to believe that recipient participation rates are any higher than the 2 to 5 percent level quoted in the HCFA report.

Mandatory SSOPs Have Proven Successful

Lack of public acceptance has been recognized as the major shortcoming of voluntary SSOPs and more third party insurers are turning to mandatory programs. For example, Blue Cross and Blue Shield of Minnesota became the first Plan in the country to establish a mandatory SSOP when, beginning October 1, 1982, its largest subscriber group -- the employees of the State and the State University -- was required to obtain second opinions before elective surgery, or the Plan would not pay. Another Plan, Blue Cross of Iowa and the Health Policy Corporation of Iowa both recently recommended a mandatory SSOP to the State Insurance Commissioner.

It is the Medicaid program, however, that is experiencing the most growth in mandatory SSOPs. Seven State Medicaid Agencies responding to our queries stated that mandatory SSOPs were incorporated into their Medicaid programs. New Jersey, Washington and Missouri had recently begun their SSOPs and could not estimate the potential savings although New Jersey did anticipate a substantial improvement in the quality of care. Connecticut, which started its SSOP on October 1, 1982, estimated that it will save about $715,000 during the first year of operation.

Three other State Agencies had more experience with their SSOPs. These states -- Massachusetts, Michigan and Wisconsin -- focused their SSOPs on up to ten selected surgical procedures that, in their opinion, had the highest incidence of inappropriate surgery. Medicaid would not reimburse the physicians for performing the surgery without a second opinion. The recipients, however, retained their right to make the final decision whether or not to have the operation. The three states reported that their SSOPs were effective in reducing elective surgeries and associated costs.

MASSACHUSETTS

> The Massachusetts SSOP was mandated by the Legislature in 1977 in an effort to curb rising medical costs and reduce unnecessary surgery. In January 1982, an independent group of reviewers published an evaluation report on the SSOP. Two approaches were used: a study of the program experience and surgery decisions of 2,501 program referrals, and an analysis of Medicaid surgery

rates before and after program implementation. The major findings of this evaluation were:

...The SSOP saved Medicaid $3 to $4 for every dollar spent. Cost savings were computed at more than $1 million per year.

...Overall surgery was estimated to have dropped by 20 percent in the year after program implementation. The greatest percentage declines were for hysterectomies (26 percent); meniscectomies (23 percent); and hemorrhoidectomies (23 percent).

...The decline in surgery rates was attributable both to a direct effect on patients referred to the program and to a sentinel effect whereby fewer operations were proposed.

MICHIGAN

The Michigan SSOP was implemented in three phases beginning on January 1, 1980 and ended June 30, 1980. A preliminary evaluation performed by the Michigan Department of Social Services found that as of November 1, 1981:

...surgical utilization for the procedures included in the SSOP dropped about 35 percent. The greatest percentage declines were for dilation and curettage (41 percent); tonsillectomies and/or adenoidectomies (40 percent); and hemorrhoidectomies (32 percent).

...estimated annual cost savings were about $3.7 million per year.

WISCONSIN

The Wisconsin Department of Health and Social Services, in a report to its State Legislature, reported the results of its evaluation of its mandatory SSOP. The evaluation covered the period February through September 1981 and consisted of an anlaysis of 1) data generated as part of the second opinion process, 2) historic data on the frequency of surgery, and 3) a survey of Medicaid recipients participating in the SSOP. The evaluation also incorporated the use of "control group" surgical procedures and the monitoring of other factors which might influence surgical utilization -- the mix of the Medicaid population, the number of physicans participating in Medicaid and the use of physician services. The major findings of the evaluation were:

...The SSOP netted over $2.8 million in total savings -- $1.8 million in total Medicaid savings and almost $1 million in Medicare savings.

...The SSOP overall returned almost $22 in savings for every $1 of program costs.

...Overall surgery was estimated to have dropped by 33 percent as a result of the SSOP. The percentage drop varied by procedure and ranged from 17 percent to 48 percent. The control procedures did not show similar, consistent drops. The greatest percentage declines were in dilation and curettage (47.5 percent); tonsillectomy/adenoidectomy (35.3 percent); and varicose veins (35 percent).

...Much of the drop in surgery was due to sentinel effect.

The studies pointed out that the cost savings were not attributed solely to non-confirming second opinions. Massachusetts and Wisconsin reported that from 70 to 90 percent of the savings were due to the sentinel effect - a phenomenon whereby physicians initially recommend fewer surgeries because of awareness that their decisions to operate will be reviewed by other physicians. Obviously, the sentinel effect by its very nature will have more of an impact on a mandatory program than on a voluntary SSOP. HCFA, in reporting on its voluntary programs, stated that "it seems unlikely that a significant sentinel effect would exist, since utilization of these programs is extremely low".

Other studies are available which demonstrate the effectiveness of mandatory SSOPs. HCFA in its report to Congress stated that sponsored studies have shown mandatory SSOPs to be cost-effective in both the public and private sectors. One such study[4] described eight years of experience with the Cornell-New York Hospital SSOP. The program data revealed that 18.7 percent of program participants were advised not to undergo surgery by consultants and that, after one year, 61.4 percent of them had no surgery performed. Most of these patients stated their decision not to have surgery was based upon the advice of the second physician. Interestingly, over one-half of these recipients reported they received no medical treatment after the consultation. The researchers questioned why surgery had been recommended in the first place and classified this as potential surplus surgery. The report concluded that "the demonstrated cost savings potential of a mandatory second opinion program justified the inclusion of such a program in the array of cost containment initiatives already adopted or under consideration as means of controlling the rise in medical care costs".

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[4] Health Care Financing Administration Office of Research, Demonstrations and Statistics. Eight Years' Experience With A Second Opinion Elective Surgery Program: Utilization and Economical Analysis. March, 1981

The National Governors' Association came to the same conclusion. After reviewing the experience that several State Medicaid programs have had with mandatory SSOPs, the Association concluded that "mandatory programs which focus on procedures that are high volume, high cost, and often non-confirmed have the potential to be very cost-effective".

National Impact of Mandatory SSOPs Would Be Significant For Both Medicaid and Medicare

Studies on SSOPs have pointed out two irrefutable facts. One, voluntary SSOPs have a limited impact on the number of elective surgeries performed nationally. Two, mandatory SSOPs lead to a substantial reduction in the number of elective surgeries and are cost effective. For example, as previously mentioned, the three states that had performed cost studies all concluded that the SSOPs will result in a 20 to 35 percent reduction in elective surgeries at annual cost savings of from $1 million to $3.7 million -- an average of $3.48 for each Medicaid recipient residing in the three states. Projecting this average saving per recipient to all Medicaid recipients, we estimate that a mandatory SSOP applied nationally could save as much as $63 million annually.

A mandatory SSOP should also be effective in Medicare considering the number of Medicare beneficiaries and the fact that the elderly have surgery performed twice as often as the rest of the population. We estimate that a mandatory SSOP for just nine surgical procedures could reduce elective surgeries annually by 18 percent at cost savings totaling about $94.7 million (see APPENDIX A).

Our estimates are based primarily on an extrapolation of statistical data included in the HCFA report to Congress and an independent study[5/] of the two voluntary SSOPs. HCFA attributed a maximum reduction of 12 percent in elective surgeries to the SSOPs, and the independent researcher identified a potential net savings of $382 for every Medicare beneficiary participating in the New York SSOP. In estimating our surgical reduction rates by surgical procedure, we used the same methods and statistics used by HCFA except that we adjusted them by two known factors attributed to mandatory programs:

1. Lower rate of non-confirmations. - A non-confirmation occurs when the second physician advises against the proposed surgery. In its report to Congress, HCFA stated the non-confirming rate of second opinions was generally 10 percentage points lower than for voluntary

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[5/] Poggio, E.C., Kronick, R., Goldberg, H., et. al. Second Surgical Opinion Programs: An Investigation of Mandatory and Voluntary Alternatives. Cambridge, Massachusetts: Abt Associates., Inc., September 1981

SSOPs. Consequently, in our extrapolation of HCFA data, we used a 20 percent non-confirmation rate rather than the 30 percent computed by HCFA.

2. The sentinel effect. - The sentinel effect played a major role in reducing elective surgeries in mandatory SSOPs but not in voluntary programs. In our extrapolation, we used the sentinel effect reported by Massachusetts. Massachusetts was selected because it was the only one of three SSOPs which was independently evaluated, and the surgery reduction rate attributed to the SSOP was the most conservative -- a 20 percent reduction. Using the HCFA computation method we calculated that 60.5 percent of the reductions in surgeries experienced by Massachusetts were due to the sentinel effect.

With regard to our cost estimates, we used, to the extent possible, net savings by procedure as reported in an independent study [6] of the Massachusetts Medicaid program. When Massachusetts data was not available, we used net cost savings developed by the Wisconsin Department of Health and Social Services. To ensure ourselves of the reasonableness of Wisconsin's computed savings, we compared the surgeon fees used in their calculations to the average prevailing surgeon fees reimbursed by Medicare. The prevailing fees were higher in every case.

Medicare's estimated cost savings is substantial because many of the surgical procedures included in the SSOPs are commonly experienced by individuals 65 years of age and older, of whom about 95 percent are covered by Medicare. Some of the more common procedures experienced by the elderly during 1980 and the potential effect of a mandatory SSOP on these procedures follow:

Surgery of the Prostate - This type surgery, which is among the five most commonly experienced by the male population 65 years of age, and older, is generally considered to be suitable for second opinions. Wisconsin, however, limits second opinions to a single procedure - Transurethral Resection Prostate. About 80,939 of these operations were performed in 1980 and, based on available statistics, about 55,976 of them were performed on Medicare beneficiaries. The Wisconsin and Cornell mandatory SSOPs both report that patients initially recommended for this type of surgery have high rates of non-confirmation. Based on the New York Medicare SSOP's estimate as adjusted

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6/ Poggio, E.C. and Goldberg, H.B. The Mandatory Second Surgical Opinion Program for Medicaid in Massachusetts: A Cost Effectiveness Analysis. Cambridge, Massachusetts: Abt Associates, Inc., November 1982 by the sentinel effect, we estimate that 27.8 percent of these surgeries, or 15,562, may have been avoided at a net savings of $43.2 million.

Cholecystectomy - This is the second most frequently performed surgery among elderly women, and second opinions are generally recommended. About 131,515 operations were performed in 1980, of which 32,233 were performed on Medicare beneficiaries 65 years of age and older. Massachusetts, Michigan and Wisconsin's average avoidance rate was 17.9 percent. For purposes of our estimate, we used the New York Medicare SSOP's experience of 14.9 percent (modified for sentinel effect). As many as 4,803 surgeries may have been avoided at a net savings of $10.3 million.

Joint Replacement - This is the third most frequently performed surgery among women over age 65. About 35,003 operations of this nature were performed on Medicare beneficiaries in 1981. Using New York's reduction rate as adjusted by the sentinel effect, 5,460 of these surgeries, at an estimated savings of $28.1 million, may have been avoided had second opinions been required.

Hernia Repair - This is also among the five most commonly experienced surgeries by the population over 65. Eight years of experience with the Cornell study show that it is one of the highest in terms of
cessary surgery. In fact, the study questions
er a good percentage of patients initially
ended for hernia repair actually had a hernia
Both Wisconsin and Michigan reported a re-
rate of over 20 percent. Medicare's New York
nce was much lower. Using the lower figures,
timate that 1,557 of the 33,845 hernia operations may have been avoided under a mandatory SSOP, at a net savings of about $1.4 million.

Recommendations

We recommend that the Administrator, HCFA, through appropriate legislative channels, seek a change to the Social Security Act that would require all states to adopt mandatory SSOPs for the Medicaid program, and all Medicare beneficiaries to obtain second opinions for selected surgery as a condition for Medicare reimbursement. In carrying out the recommendation, HCFA should (1) waive all co-payment and deductible requirements for Medicare beneficiaries seeking second opinions as was done in the two demonstration projects, and (2) select a minimum number of surgical procedures that must be incorporated into the SSOP. State Medicaid Agencies should retain their prerogative of adding to the list of procedures.

Discussion of HCFA's Comments To Draft Report

HCFA did not agree with our recommendation to seek legislative approval for a mandatory SSOP. In its reply (see APPENDIX B), HCFA listed several concerns relative to our cost estimates and certain technical medical and operational issues. Its primary concern, however, was that although mandatory SSOPs appear to be more cost effective than voluntary programs, there is not enough experience in the public and private sectors to seek legislative approval. This is particularly true with respect to the impact of mandatory SSOPs upon Medicare beneficiaries. HCFA estimated that 3 to 4 years of study are needed before it can even consider implementing a mandatory SSOP on a national basis.

HCFA should reconsider our recommendation as further studies, in our opinion, will not add anything substantial to what is already known about SSOPs. HCFA has spent over $2.5 million in SSOP evaluations. In its report to Congress, HCFA quite clearly summed up the results of their studies when it concluded:

> ...Sponsored studies have shown mandatory SSOPs to be cost-effective in both the public and private sectors.
>
> ...The most striking fact regarding all voluntary SSOPs is that few people choose to use them.

If HCFA's conclusions are correct -- and based on our review of SSOP evaluations, they are -- we fail to see the need for 3 to 4 years of study. This holds true for most of the other issues raised by HCFA. Sufficient studies are already available for HCFA to make determinations such as who will render second opinions and who will be at risk if beneficiaries do not obtain second opinions.

In response to HCFA concerns relative to our estimated cost savings, we have made several changes to this report. For example, in estimating our cost savings, much more emphasis was placed on the results of the two Medicare demonstration projects rather than solely on Medicaid experience in three states. Avoided operations were computed using statistics taken from the study of the Medicare projects and modified to account for the sentinel effect. Net savings for specific surgical procedures were based on statistics taken from an independent study -- funded by HCFA -- of the Massachusetts Medicaid program whenever possible. While these revisions have reduced our estimated cost savings to the Medicare program, the amount remains substantial -- $94.7 million.

In summary, we believe the basic issue is this -- are second opinions an effective means of reducing unnecessary surgeries? If second opinions are effective in reducing unnecessary surgeries, then every effort should be made to expand their use. If, on the other hand, second opinions are not an effective means of reducing unnecessary surgeries, they are meaningless at best, harmful at worst, and should be neither encouraged nor expanded.

As pointed out in our report and as mentioned specifically in HCFA's response, HCFA continues to vigorously support voluntary SSOPs. So too do most Blue Shield plans and the large majority of State Medicaid programs.

Based on this wide support, we can only conclude that second surgical opinions are a valuable addition to the national health care network and that their use should be maximized. It is clear that voluntary SSOPs will not significantly increase the use of second opinions. It is equally clear that mandatory SSOPs will. We urge HCFA to initiate legislative action to require mandatory SSOPs for both the Medicare and Medicaid programs.

ESTIMATED COST SAVINGS
MEDICARE PROGRAM

Surgery	Total 1/ Operations	Medicare 2/ Beneficiaries	Surgery 3/ Reduction Rate	Avoided 4/ Operations	Net Savings Single	Net Savings Total
Prostate - TUR	80,939	55,978	27.8	15,562	$2,774	$43,168,988
Joint Replacement	63,746	35,003	15.6	5,460	5,144	28,086,240
Hernia Repair	146,610	33,845	4.6	1,557	886	1,379,502
Cataract	34,106	21,157	23.3	4,929	1,386	6,831,594
Cholecystectomy	131,515	32,233	14.9	4,803	2,142*	10,288,026
Varicose Veins	18,598	2,014	37.7	759	1,218*	924,462
Hysterectomy	188,211	10,907	22.8	2,487	1,176*	2,924,712
Hemorrhoidectomy	44,028	4,643	16.7	775	817*	633,175
Dilation and Curettage - (D&C)	253,796	8,439	10.9	920	560	515,200
	961,549	204,219		37,252		$94,751,899

1/ Represents the total number of patients whose operations were performed in hospitals within the United States in 1980

2/ Estimate is based on the percentage of individuals 65 years of age or older who were operated on in hospitals located in the Northeastern and Southern regions of the country during 1980, projected to the total number of individuals who were pperated on nationally. Based on HCFA statistics, about 95 percent of individuals 65 and over are covered by Medicare.

3/ Surgery reduction rate was based on the results of the New York Medicare demonstration project modified by the impact of the sentinel effect which applies to mandatory SSOPs.

4/ Those marked with a * were taken from the independent study of the Massachusetts Medicaid program. The other amounts were developed by the Wisconsin Department of Health and Social Services.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Financing Administration

Memorandum

Date 22 JUN 1983

From Carolyne K. Davis, Ph.D. Carolyne K. Davis
Administrator
Health Care Financing Administration

Subject Office of the Inspector General Final Report—A Mandatory Second Surgical Opinion Program Would Prove Beneficial to the Medicaid and Medicare Programs (ACN 03-30211)

To The Inspector General
Office of the Secretary

We have reviewed the final report which recommends a mandatory second surgical opinion program (SSOP) for Medicaid and Medicare. We agree that there is some evidence that a mandatory SSOP might reduce the amount of surgery performed for both Medicare and Medicaid beneficiaries resulting in some cost savings.

We are pleased to see that the results of HCFA's second opinion studies were taken into account by the OIG in revising the initial cost savings estimates. We note, however, that the final report does not deal with a number of important questions that we raised in our response to the draft report. For example, no mention is made of the administrative cost of implementing mandatory SSOP's, their long-term impact on Medicare and Medicaid benefit payments, the cost of waiving all of the Medicare deductibles and coinsurance requirements and the long-term effect on participating patients' health outcomes.

To alleviate some of our concerns that were not addressed in the final report, there are several courses of action that we plan to immediately pursue. As stated in our response to the draft, HCFA has contracted with ABT Associates, Inc. to evaluate the voluntary Medicare SSOP in New York and the mandatory Massachusetts SSOP. The results of these evaluations should provide much of the needed information on the effects of a mandatory SSOP and the long-term cost savings from such a program. These evaluations will be completed by September 1983.

Additionally, HCFA is scheduling meetings with the private sector (Blue Cross of Minnesota and Prudential) and the States of Massachusetts, Michigan and Wisconsin to learn more about their experience and administrative problems with mandatory SSOPs. A mandatory SSOP for both the Medicare and Medicaid programs would be by far the largest SSOP ever attempted. For example, the five most frequent elective surgical procedures among Medicare beneficiaries now account for more than one million operations annually.

In view of the questions that remain unanswered in this area, HCFA is in the process of conducting a more rigorous examination of the mandatory programs that have been implemented in both the public and private sectors.

If you have any questions or require additional information, please contact Linda Schmidt of the Audit Liaison Staff on FTS 934-7491.

Audit

American College of Surgeons

FOUNDED BY SURGEONS OF THE UNITED STATES AND CANADA, 1913

55 EAST ERIE STREET CHICAGO, ILLINOIS 60611 AREA CODE 312-664-4050

C. ROLLINS HANLON, M.D., F.A.C.S.
DIRECTOR

August 10, 1983

[illegible]00056

The Honorable Margaret M. Heckler
Secretary
Department of Health and Human Services
615F Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Heckler:

The American College of Surgeons submits for your consideration our comments on the Inspector General's report on second surgical opinion programs, released in March of this year. The College is a voluntary scientific and educational organization devoted to the ethical and competent practice of surgery and to the provision of high-quality care for the surgical patient. The College provides educational programs for its more than 45,000 Fellows and others, establishes standards of practice, and disseminates medical knowledge to the general public. Our Fellowship includes surgeons in this country and throughout the world.

For several years, the College has followed closely the debate over allegations that so-called "unnecessary" operations are widespread and that they can be curbed by second surgical opinion programs. We maintain our initial contention that "unnecessary surgery" has never been defined in a satisfactory way. The arithmetical extrapolations used in 1976 during congressional hearings on this subject have been completely discredited in the professional literature. Therefore, the Inspector General's report is based on a premise not supported by facts. Failure to acknowledge the inaccurate and misleading extrapolations regrettably undermines the credibility of the report.

The College believes that both the incidence of "unnecessary surgery" and the cost-effectiveness of second surgical opinion programs have been overstated. The original research on second opinion programs from New York City contains serious statistical and methodological errors. The reliability and validity of the research results have never been documented in an acceptable fashion. Thus, the cost-effectiveness of these programs is questionable at best.

In spite of such failings, second surgical opinion programs have been praised as an effective means of health care cost containment. We may point out that Blue Cross and Blue Shield of Greater New York began their second surgical opinion program as a cost containment measure, only to find that the program encouraged, rather than discouraged, patients to have operations, thus increasing the costs to the insurance company.

The Honorable Margaret M. Heckler
Page two
August 10, 1983

The College must disagree with the comment in the Inspector General's report that mandatory second surgical opinion programs have proved successful. The College opposes mandatory programs because they inappropriately limit the freedom of the patient, complicate the management of the patient's illness and do not raise the standard of care in a clearly demonstrable way. As to their cost-effectiveness, we should cite the following:

1. Cost-benefit analyses are speculative. They are predicated on guesswork as to the percentage of patients who might choose not to have operations and the amount of dollars potentially saved if the operations are not done. The medical costs of postponing or not having an operation are overlooked. In the long run, these may exceed the cost of operation.

2. One cost-benefit analysis of the Massachusetts program showed the claimed net benefits to be quite small (benefit-cost ratio = 1:1.11). This ratio would not yield the million dollar savings cited in the Inspector General's report.

3. The Wisconsin Department of Health had its program in operation for only seven months in 1981 when it concluded it was successful. The department used 1980 as the comparison year. Surgical rates in 1980 were higher than normal in Wisconsin for unexplained reasons. Had the department used 1979 as the comparison year, the results would show an increase in the number of operations for Medicaid patients under the second surgical opinion program.

We should note that the Inspector General's report cites only the literature that supports second surgical opinion programs. It ignores the considerable body of literature with a critical or negative opinion of these programs.

Finally, we commend the cautious response of Carolyne Davis, Ph.D., Administrator of the Health Care Financing Administration, regarding a draft version of the Inspector General's report, and emphasize her concerns about the limitations of these program.

The College respectfully requests your consideration of these points before accepting the recommendations set forth in the Inspector General's report on second surgical opinion programs.

Sincerely,

C. Rollins Hanlon

C. Rollins Hanlon, M.D., F.A.C.S.

CRH:bc

cc: Carolyne Davis, Ph.D.

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

OCT 5 1983

C. Rollins Hanlon, M.D., F.A.C.S.
Director
American College of Surgeons
55 East Erie Street
Chicago, Illinois 60611

Dear Dr. Hanlon:

We would like to take this opportunity to thank the American College of Surgeons for long standing commitment to assuring the highest quality of surgical care to all Americans.

We also, greatly appreciate receiving your comments on the Inspector General's report on second surgical opinion programs. The issue of whether or not to implement a mandatory second surgical opinion program for Medicare and/or Medicaid patients warrants careful deliberation. In addition to the Inspector General's report, we will be carefully considering the final results of the Health Care Financing Administration's (HCFA) evaluation of the voluntary Medicare second surgical opinion programs in New York and the mandatory Medicaid second surgical opinion programs in Massachusetts.

The College's Department of Surgical Practices has reviewed and commented on earlier reports emanating from this HCFA study. Your comments on the final report will be particularly useful to the Department as we examine our policies toward second opinion surgery for Medicare and Medicaid beneficiaries. We anticipate receiving study findings during the fall. Should you have any questions about the study, do not hesitate to have your staff call the HCFA project officer, Mr. Alan Friedlob, at (301) 597-2364.

In addition to considering the final results of the HCFA evaluation, we are also planning to meet with representatives of several private sector and State Medicaid mandatory second surgical opinion programs to learn more about their experience.

Thank you again for sharing with me the position of the American College of Surgeons on second surgical opinion programs.

Sincerely,

/s/ Margaret M. Heckler

Margaret M. Heckler
Secretary

3403

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

HCFA File

Memorandum

Date NOV - 7 1983

From Carolyne K. Davis, Ph.D.
Administrator, Health Care Financing Administration

Subject Development of a Second Surgical Opinion Program for Medicare

To Robert J. Rubin, M.D.
Assistant Secretary for Planning and Evaluation

The IG has recommended that Medicare develop a mandatory second surgical opinion program. The IG has specified a list of procedures for which second opinions should be sought before Medicare would reimburse for the surgery. (See attachment) I would appreciate your comments on this list as well as your suggestions as to which surgical procedures you think it is appropriate to include in a mandatory second opinion program. I would also appreciate suggestions on the design of a mandatory as well as an expanded voluntary second surgical opinion program for Medicare.

Interest has been expressed in the possibility of including this proposal in the Department's FY85 legislative package. I would appreciate it if you could provide your comments to George J. Schieber, Director of the Office of Policy Analysis by November 15.

Thank you.

Attachment

cc. Richard P. Kusserow

ESTIMATED COST SAVINGS
MEDICARE PROGRAM

Surgery	Total 1/ Operations	Medicare 2/ Beneficiaries	Surgery 3/ Reduction Rate	Avoided 4/ Operations	Net Savings Single	Net Savings Total
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4/ Those marked with a * were taken from the independent study of the Massachusetts Medicaid program. The other amounts were developed by the Wisconsin Department of Health and Social Services.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Office of the Secretary
Washington, D.C. 20201

NOV 21 1983

OLP/Schieber:FYI
cc:CDavis, DBourque
KButo, AAP, Spiegel
Broglie, MThomas

TO : Carolyne K. Davis
Administrator, HCFA

FROM : Robert J. Rubin, M. D.
Assistant Secretary for
Planning and Evaluation

SUBJECT: Development of a Second Surgical Opinion Program Under Medicare

This is in reply to your request for my comments on the enclosed list of procedures recommended by OIG for a mandatory second surgical opinion program. We have also received a draft outline of specifications for such a program informally from your staff. My comments on both follow:

1) Procedures--Coronary bypass surgery should be added to the nine procedures mentioned in the OIG list.

2) Program Structure

   a) The section on the beneficiary's right to make the final decision on whether to elect surgery should be clarified. I assume this means Medicare will pay for surgery even if the second opinion or third opinion is non-confirming as long as a second opinion is obtained.

   b) Medicare should not set up a network of second opinion physicians. Existing referral mechanisms should be relied upon. This of course obviates the proposal for an enrollment fee for second opinion physicians.

   c) Waiver of coinsurance is not necessary in a mandatory second surgical opinion program. In a voluntary program it is an incentive to encourage beneficiary participation, but serves no similar purpose under a mandatory program.

HCFA/EXEC.SEC.
1983 NOV 22 AM 8 44

DEC 13 1984

NOTE TO: Phil Nathanson (Director, Health Standards and Quality Bureau, HCFA)
SUBJECT: Onsite Visit Reports

Following is a summary of the results of the regional office evaluation of PRO implementation. This evaluation is scheduled for 30 days after the effective date of the PRO contract. A total of 34 reports of onsite visits has been received from ROs. The most serious problems contained in the reports concern PATBILL tapes and data processing which are impeding the implementation of PRO review and achievement of impact objectives. Other problem areas are local problems to be resolved on a PRO by PRO basis.

I. Major problems

A. PATBILL Tapes

The lack of acceptable PATBILL tapes is delaying implementation of review and objective impact activities. Twenty-one (21) reports mention problems with PATBILL tapes including delayed receipt of claims, high error rates, and problems with new systems. A fiscal intermediary (FI) transmittal was released on December 6 and was discussed with FIs during a conference call on December 7. This discussion should have resolved all edit problems. Implementation is required by January 1, 1985.

B. FI Agreements

The reports show that a number of PROs do not have final FI Agreements yet. The RFP states that "the contractor shall execute an agreement acceptable to HCFA with each FI in its area before it begins making denial determinations but no later than 45 days after the contract effective date."

- Eighteen PROs have finalized FI agreements for their areas, seven of which need to be revised.
- Sixteen PROs still need to finalize FI agreements for their areas.

- o Disagreement on the provision of PRICER data is holding up agreement between New Hampshire and its FI. The project officer has been in contact with central office and a letter is going out to the PRO shortly which should solve the issue.

  As of November 30, the following PROs, whose onsite visit reports we received, did not have signed FI agreements and are beyond the 45-day period for obtaining such:

  Alaska
  Arizona
  California
  Florida
  Georgia
  Mississippi
  Nevada
  New Hampshire
  New York
  North Carolina
  Rhode Island
  South Carolina
  South Dakota
  Tennessee
  Washington
  West Virginia

  Project officers report that a number of agreements are close to being finalized and a few will take longer, but denials are being made based on interim, draft, or unwritten agreements.

C. Data Processing

- o The Delaware PRO was not able to reach agreement with its anticipated data processor; the PRO may do its own processing. The impact on review has been negligible because the PRO is performing 100% review onsite, but profiles have not yet been developed.

- o Missouri's processor (Wisconsin Physician Service (WPS) is under penalty provisions for failure to meet deliverables. They have no capability to process a tape for return to FI after medical review. System mods will be very costly. RO has recommended that Missouri examine alternatives to their WPS contract.

- o The data processor in Nevada wants additional funds for the increase in the number of runs caused by bad tapes. The project officer has informed them to keep track of the costs due to bad tapes until the problem is resolved so that funding can be accomplished in one request for modification rather than many.

II. Other problem areas:

A. Hospital Agreements

The 34 reports submitted indicate that the signing of final hospital agreements is moving slowly. The lack of final agreements, however, has not hindered access to the hospitals for review by PROs.

- Seven PROs have final agreements with some of their hospitals.
- Four PROs have interim agreements with their hospitals.
- Twenty-three PROs had no signed agreements with their hospitals at the time of their onsite visits. They are:

Alabama
Alaska
Colorado
Delaware
Florida
Georgia
Iowa
Kentucky
Minnesota
Mississippi
Missouri
Montana
New Hampshire
New Mexico
New York
North Carolina
Oregon
Rhode Island
Tennessee
Virgin Islands
West Virginia
Wisconsin
Wyoming

Project officers do not anticipate problems with obtaining agreements with hospitals, nor is review being impeded.

B. Staffing

Staffing does not appear to present problems except in area of qualified DRG reviewers. Washington is having difficulty hiring ARTS with coding experience, and California reports difficulty in hiring an RRA.

C. Hospital Review Implementation

Hospital review implementation is on target for most areas reported on. Arizona was delayed in starting review because useable paid claims data were not received on time. Nevada is now conducting special category case reviews as indicated by FI hardcopy, cost and day outlier review when advised by the hospitals and preadmission review. Other areas have not been implemented because PATBILL data have not been available.

D. Criteria

The majority of PROs submitted the criteria required within 45 days. Several are behind schedule but intend to submit them shortly.

E. Case Identification

Washington and West Virginia PROs report problems with case identification due to lack of useable PATBILL tapes. In Washington the PRO is negotiating with the FI and a meeting has been set up with central office personnel to resolve the issue. In West Virginia the RO and the PRO are discussing resolution efforts with Mutual of Omaha. Although not specifically mentioned in other reports, case identification would generally be a problem in most areas where PATBILL problems exist.

F. Objectives and PPS Review

Activities to implement objectives and PPS Review have been delayed due to delays in claims submitted and lack of clear PATBILL tapes. Several other problems were reported.

- Louisiana has been catching up with PSRO backlog rather than reviewing current admissions. The project officer has notified them that review must be initiated within the required timeframes and that a schedule must be submitted which shows how the backlog will be completed while current claims are being reviewed.

- Nevada will have no PATBILL data until January and is only performing preadmission review and cases referred by the FI or hospitals.

- Evaluation of review coordinator (R.C.) performance by the RO in New Mexico found areas where improvement in medical record review is needed. The sample of records contained instances where the R.C. failed to refer admissions where the principal diagnoses assigned or the medical necessity of the admission were questionable. Clinical findings in the records failed to support either the diagnosis or the acuteness of the patient's condition. A detailed letter was sent to the PRO listing the deficiencies found and requiring a plan of correction addressing five specific areas.

G. Other

Region VII is concerned that the Missouri PRO has five semi-autonomous areas rather than one PRO. The PRO regional offices sent out different types of reports to the hospitals following onsite reviews and send different denial letters. A lack of cooperation by PRO regional office staff and overly independent actions by subcontractors have been observed. Consistency of the review program across the State and clear management control by the prime contractor are needed. The RO has conveyed its concerns to the PRO and is closely monitoring the situation.

Follow-up inquiries with ROs will be made to determine progress in problem areas and areas not addressed in the reports.

Allen Lazar
(Director, Office of Medical Review,
HSQB, HCFA)

HSQB/OMR/DFO/PAB/Dianne Coughlan/jl/11-13-84/2189A
Revised/MPlunkett/jl/ 11-15-84
Revised/MPlunkett/jl/11-20-84
Revised:Tirone:jg:12/03/84
Revised:Lazar:la:12/5/84
Revised:Tirone:jl:12-10-84

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Memorandum

Date Oct.

From Chairman
PPS Monitoring Committee

Subject Report on PPS Monitoring Activities — December 20, 1984

To The Administrator

Significant Developments

- A total of 5,405 or 81 percent of all hospitals are now on prospective payment.
- Total short-stay hospital admissions for October 1983 through September 1984 (11.495 million) decreased slightly from the number reported for October 1982 - September 1983 (11.696 million). Adjusted for Leap Year, this represents a 2.0 percent decrease in admissions.
- There were an estimated 959,000 short-stay hospital admissions in October 1984, down 2.5 percent from October 1983.

PPS Phase-In Status

- 5,405 hospitals were operating under PPS as of September 30, 1984. This is 81 percent of all hospitals. (Source: BPO-PPS Summary Report through September 1984) (Note: This report is no longer prepared.)
- Cumulative FY 84 benefit payments under PPS were $15.8 billion through September 1984. This was 42 percent of all payments for inpatient hospital services reported this period. Benefit payments under PPS were $3.8 billion during October 1984, the first month of FY 1985. This was 84 percent of all payments for inpatient hospital services. Cumulative benefit payments include retroactive adjustments to PIP rates and accelerated payments. (Source: BPO-PPS Intermediary Benefit Payment Reports through October 1984)
- The total number of certified exception units are as follows: psychiatric 729; rehabilitation 308; alcohol/drug 241. (Source: BPO Implementation Report through October 1984)

- The number of certified hospitals not under PPS are: short-stay hospitals in waiver States 552; psychiatric hospitals 439; rehabilitation hospitals 51; alcohol/drug hospitals 25; other 137 (long-term care 88; childrens 49). (Source: BPO Implementation Report through October 1984 and HSQB Provider Certification Process)
- The number of facilities given special consideration under PPS are: regional referral centers 46; cancer treatment centers 4; Mayo Clinics 6, sole community hospitals 308. (Source: BPO Implementation Report through November 1984)

Admissions

- The preliminary estimate of Medicare short-stay hospital admissions for FY 84 is 11.495 million, a 1.7 percent decrease from the 11.696 million admissions recorded in FY 83. Adjusted for leap year, this represents a 2 percent decrease. The revised estimate for all inpatient admissions (short-stay, long-stay, and excluded units) during FY 84 is 11.7 million, down 0.8 percent from 11.8 million admissions in FY 83. (Source: Admission notices from Query/Reply System processed in BDMS through October 1984 and OFAA Actuarial estimates)
- A preliminary estimate of the number of Medicare short-stay hospital admissions during October 1984, the first month of FY 85, is 959,000. This represents a decrease of 2.5 percent from October 1983.

Admission Pattern Monitoring

- 1,446 hospitals were identified for review because of an increase in discharges during FY 1983. Thirty-one (31) percent had corrective action plans initiated, 54 percent required no additional action, and 15 percent are still being investigated. (Source: BDMS APM reports and Summary of HSQB Report of Medical Review Activity, September 1984)
- For the first three quarter of FY 1984 (October 1983 - June 1984) 1,322 hospitals were identified for review because of an increase in discharges. (Source: BDMS Quarterly APM Reports)
- HSQB plans to redirect the use of APM to a PRO performance monitoring device.

Case-Mix and DRG

- The ten most frequently occurring DRGs reported for PPS discharges are:

FY 84 Rank	CY 81 Rank	DRG	Discharges	Percent of PPS
1	1	127 - Heart Failure and Shock	208,272	4.7
2	2	182 - Esophagitis, Gastroenteritis Miscellaneous Digestive Disorders, Age Over 69 and/or Complicating Conditions	165,182	3.7
3	4	039 - Lens Procedure	161,484	3.7
4	6	014- Specific Cerebrovascular Disorders Except Transient Ischemic Attacks	131,927	3.0
5	11	140 - Angina Pectoris	131,099	3.0
6	7	089 - Simple Pneumonia and Pleurisy, Age Over 69 and/or Complicating Conditions	130,504	3.0
7	12	243 - Medical Back Problems	89,029	2.0
8	13	138 - Cardiac Arrhythmia and Conduction Disorders, Age Over 69 and/or Complicating Conditions	87,656	2.0
9	5	088 - Chronic Obstructive Pulmonary Disease	87,305	2.0
10	21	296 - Nutritional and Miscellaneous Metabolic Disorders, Age Over 69 and/or Complicating Conditions	75,328	1.7

(Source: Case Mix Monitoring Tables using PATBILL records processed in BDMS through November 30, 1984)

- DRG 468 cases were 1.2 percent of all reported PPS bills through September 30, 1984. These are undergoing further review. (Source: BPO-PPS Summary Report through September 1984) (Note: This report is no longer prepared.)

- Based on PATBILL records received to date, DRG 468 ranks 19th by frequency. The average reimbursement per discharge for DRG 468 (excluding passthrough payments) is $5,920 compared to $2,915 per discharge for all PPS bills. (Source: PPS Monitoring Tables using PATBILL records processed in BDMS through November 30, 1984)

- The case mix index for PPS bills through September 1984 was 1.1278 compared to 1.0534 in 1981, 7.4 percentage points higher. (Source: Case-Mix Monitoring Tables using PATBILL records processed in BDMS through November 30, 1984.)

Length of Stay

- o Based on PATBILL records received to date, the average number of days per bill for all hospitals (short-stay and long-stay) was 8.9 days during October 1983 - September 1984. The average days per bill for corresponding period in previous year (during October 1982 - September 1983) was 9.6. The corresponding averages for short-stay hospitals are 8.6 days (October 1983 - September 1984) and 9.3 days (October 1982 - September 1983). (Source: PPS Monitoring Tables using PATBILL records processed in BDMS through November 30, 1984)

- o The average length of stay per discharge for PPS hospitals was 7.4 days during October 1983 - September 1984. The average length of stay is influenced by the geographic distribution of PPS hospitals and slower reporting of more complex cases subject to review. (Source: PPS Monitoring Tables using PATBILL records processed in BDMS through November 30, 1984)

Outliers

- o Outliers are 2.1 percent of total PPS discharges reported through September 30, 1984. This broke down into 0.5 percent cost outliers and 1.6 percent day outliers. (Source: BPO-PPS Summary Report through September 1984) (Note: This report is no longer prepared.)

Transfers

- o Distribution of Bills by Discharge Status

	Cumulative through -			
	9/30/84	8/31/84	7/31/84	6/22/84
Total	100.0%	100.0%	100.0%	100.0%
Home, Self-Care	80.8	81.0	81.2	81.6
To Short-Term Hospital	1.7	1.7	1.6	1.6
To SNF	5.4	5.3	5.2	5.1
To ICF	2.7	2.7	2.7	2.6
To Other Facility	0.9	0.9	0.9	0.8
To Home Health Service	3.0	3.0	2.9	2.9
Against Medical Advice	0.2	0.2	0.2	0.2
Died	5.3	5.2	5.3	5.2

(Source: BPO-PPS Summary Report through September 1984) (Note: This report is no longer prepared.)

- The proportion of bills by discharge status has remained relatively stable since PPS began. There has been a small increase in discharges to a SNF or ICF along with a corresponding small decrease in discharges home.

Other Benefit Payments, Fiscal Year 1985

Benefit	Expenditures Reported	Expenditures Projected	Reported As % of Projected
	($ in millions)		
Outpatient	$ 288	$ --	--
Hospital	230	--	--
Other	58	--	--
HHA	156	--	--
SNF	55	--	--
Distinct Part Units	43	--	--

Note: Monthly estimates of projected benefit payments by type of service are not yet available for FY 1985.

(Source: BPO-PPS Intermediary Benefit Payment Report for October 1984)

Medical Review Activity

Forty-three PROs were performing medical review during October, the remaining 11 PROs became effective in November. The data incorporated within this report is a consolidation of review activities reported by PROs, FIs and PSROs.

- PRO Review of DRG 468s (Excludes FI/PSRO Activity)

PROs reported 78 cases of DRG 468 changes in October, 23 cases increased to a higher relative weight value and 55 cases were reduced in relative weight value. Forty-nine of the cases changed to another surgical DRG and 29 of the cases changed to a medical DRG.

For those DRG 468 cases adjusted to a higher relative weight value, the most common were as follows:

DRG	
1	Craniotomy except for trauma
112	Vascular procedures except major reconstruction
154	Minor small and large bowel procedures

For those adjusted to a lower relative weight value, the most common were:

296	Nutritional Metabolic Disorders and/or c.c.
197	Total cholecystectomy w/o common duct exploration
336	Transurethral prostatectomy

(Source: Summary of HSQB Report of PPS Medical Review Activity, October 1984)

- Admission Review

  PSROs, FIs, and PROs reported 420,826 admissions/discharges during October. Total admissions reviewed were 190,757 (45.3 percent) and total denied 3,990 (2.1 percent). Cumulatively, 4,320,238 admissions/discharges were reported with 1,307,404 reviewed (30.3 percent) and 31,829 denied (2.4 percent).

  (Source: Summary of HSQB Report of PPS Medical Review Activity, October 1984)

  - Transfers

    Psychiatric unit transfers reviewed in October total 439 cases with eight denied (1.8 percent). Cumulatively, 3,133 cases have been reviewed with 90 denied (2.9 percent).

    Rehabilitation unit transfers reviewed in October total 984 cases with 26 denied (2.6 percent). Cumulatively, 8,071 cases have been reviewed with 484 denied (6.0 percent).

    Alcohol/drug treatment unit transfers reviewed in October total 79 cases with two denied (2.5 percent). Cumulatively, 226 cases have been reviewed with 19 denied (8.4 percent).

    Swing bed transfers reviewed in October total 471 cases with 13 denied (2.8 percent). Cumulatively, 2,471 cases have been reviewed with 117 denied (4.7 percent).

    (Source: Summary of HSQB Report of PPS Medical Review Activity, October 1984)

  - Transfers From a PPS Hospital

    A total of 4,022 transfer cases were reviewed in October of which 45 were denied (1.1 percent). Cumulatively, 34,946 cases have been reviewed and 789 denied (2.3 percent).

    (Source: Summary of HSQB Report of PPS Medical Review Activity, October 1984)

  - Readmissions Within 7 Calendar Days

    In October, 11,996 cases were reviewed and 528 denied (4.4 percent). Cumulatively, 109,617 admissions have been reported with 97,698 reviewed and 3,784 denied (3.9 percent).

    (Source: Summary of HSQB Report of PPS Medical Review Activity, October 1984)

- Procedure Review

  Pacemaker insertions reviewed in October total 2,402 with 47 denied (2.0 percent). Cumulatively, 20,158 pacemaker insertions have been reviewed with 305 denied (1.5 percent).

  Other procedures subjected to medical review in October total 5,675 cases with 153 denied (2.7 percent). Cumulatively, 14,419 procedure related cases have been reviewed with 332 denied (2.3 percent).

  (Source: Summary of HSQB Report of PPS Medical Review Activity, October 1984)

- Review of Outliers

  Cases approved in the day outlier category in October were 6,406; the number of days approved were 86,697 and days denied were 8,494 (8.9 percent). Cumulatively, 54,078 cases have been approved as day outliers with 760,374 days approved and 90,329 days denied (10.6 percent).

  The most prevalent DRGs consistently reported as day outliers (both approved as well as denied) were:

  014: Specific cerebrovascular disorders except TIA
  127: Heart failure, shock
  468: Procedure unrelated to principal diagnosis

  There were 3,758 cost outlier cases approved during October. A total of $994,677 was denied (3.5 percent) of the $28,712,905 reported outlier charges in excess of the DRG threshold. Cumulatively, 24,023 cases have been reported reviewed with 4.2 percent ($7.6 million) of cost outlier charges being denied of the total $183 million reported in excess of the DRG threshold.

  The most prevalent DRGs consistently reported as cost outliers (both approved as well as denied) in October were:

  107: Coronary Bypass w/o Cardiac Cath
  148: Major small and large bowel procedures

  (Source: Summary of HSQB Report of PPS Medical Review Activity, October 1984)

- DRG Validation

  Total cases reviewed in October for DRG validation were 100,198. Of these reviews, 5,335 (5.3 percent) resulted in a change in DRG assignment. Validations include 41,868 random sample cases and represent 9.9 percent of the 420,826 reported PPS admissions/discharges during October. The remaining 58,330 validations relate to cases under review for other reasons. Cumulatively, there have been 854,654 cases reviewed for DRG validation purposes.

  (Source: Summary of HSQB Report of PPS Medical Review Activity, October 1984)

- Referrals to Regional Offices

  This report includes the number and type of review cases referred to the regional offices (ROs) by PSROs/PROs/FIs. These cases include certain transfers, readmissions within 7 days, and invasive procedures. Instructions to review entities require that ROs be provided a summary of cases where the reason for transfers is not apparent or was required by other than medical necessity; the readmission is covered yet the second stay is a result of a premature discharge; and pacemaker insertions and/or other invasive procedures where they appear inappropriate.

  During October, there were 155 referrals related to readmissions within 7 days and three related to invasive procedures. A preliminary analysis of previous months' referrals indicates they are not all due to the definition of a premature discharge affecting patient health or safety but includes a significant number of readmissions resulting from patient preference and physician practices.

  (Source: Summary of HSQB Report of PPS Medical Review Activity, October 1984)

Prospectiv- Payment System Monitoring

Bill Analysis - PPS vs Non-PPS-

	FY 84	
	Number of Bills	Amount Reimbursed(000)
All Inpatient Bills	10,713,015	$32,039,327
All PPS Bills	4,407,588	12,847,285
Non-PPS Bills	6,305,427	19,192,041
Short stay O/T waiver state	4,476,755	12,944,526
Waiver states	1,644,409	5,638,262
Psychiatric unit	30,834	115,538
Rehabilitation unit	14,802	88,756
All others[1]	138,627	404,960

[1] Includes long-stay hospitals.

Source: PATBILL Records Processed in BDMS through 11/30/84

Prospective Payment System Monitoring

Length of Stay and Reimbursement - PPS vs Non-PPS

PPS Bills	FY 84
Number of Bills	4,407,588
Average Length of Stay Per Discharge	7.4
Average Reimbursement Per Discharge (excludes pass-throughs)	$ 2,915
Percent Reimbursement of Total Charges	71.7%
All Non-PPS Bills (Short-Stay and Long-Stay Hospital)	
Number of Bills	6,305,427
Average Days Per Bill	9.9
Average Reimbursement Per Bill	$ 3,044
Percent Reimbursement of Total Charges	61.6%
Non-PPS Bills (Short-Stay Hospital other than Excluded Units)	
Number of Bills	6,121,164
Average Days Per Bill	9.4
Average Reimbursement Per Bill	$ 3,036
Percent Reimbursement of Total Charges	61.8%

Source: PATBILL Records Processed in BDMS through 11/30/84

Prospective Payment System Monitoring DRG Analysis--PPS Bills
FY 84 to Date

FY 84 Rank	CY 81 Rank	DRG No.	Relative Cost Weight	Discharges	Percent	Average Length of Stay	Average Reimbursement per Discharge
Total				4,407,588	100.0	7.4	$2,915
1	1	127	1.0408	208,272	4.7	7.6	2,602
2	2	182	0.6185	165,182	3.7	5.3	1,352
3	4	039	0.5010	161,484	3.7	2.1	1,146
4	6	014	1.3527	131,927	3.0	9.8	3,379
5	11	140	0.7548	131,099	3.0	5.0	1,758
6	7	089	1.1029	130,504	3.0	8.3	2,593
7	12	243	0.7551	89,029	2.0	7.0	1,773
8	13	138	0.9297	87,656	2.0	5.5	2,272
9	5	088	1.0412	87,305	2.0	7.4	2,573
10	21	296	0.8979	75,328	1.7	6.8	2,211
11	15	015	0.6673	74,776	1.7	5.1	1,549
12	16	096	0.7996	74,533	1.7	6.6	1,824
13	25	336	1.0079	65,673	1.5	7.3	2,585
14	26	209	2.2912	63,436	1.4	14.3	6,307
15	9	122	1.3651	61,964	1.4	9.2	3,315
16	23	174	0.9281	61,491	1.4	6.5	2,258
17	19	320	0.8123	59,627	1.4	7.1	1,878
18	10	294	0.8087	57,466	1.3	7.2	1,945
19	8	468	2.1037	52,993	1.2	13.0	5,920
20	32	210	2.0833	48,619	1.1	14.4	5,518
21	1/	121	1.8648	47,089	1.1	11.4	4,739
22	18	082	1.1400	46,452	1.1	8.3	3,039
23	38	148	2.5493	42,773	1.0	15.8	7,072
24	3	132	0.9182	41,201	1.0	5.8	2,121
25	45	087	1.5529	39,006	0.9	8.9	4,088

1/ CY 81 rank not available because previously combined with DRG 122.

(Source: Case Mix Monitoring Tables using PATBILL records processed in BDMS through November 30, 1984)

Prospective Payment System Monitoring
DRG Analysis--PPS Bills
FY 84 to Date

FY 84 Rank	CY 81 Rank	DRG Number	Description
1	1	127	Heart Failure and Shock
2	2	182	Esophagitis, Gastroenteritis and Miscellaneous Digestive Disorders, Age Over 69 and/or Complicating Conditions
3	4	039	Lens Procedure
4	6	014	Specific Cerebrovascular Disorders Except Transient Ischemic Attacks
5	11	140	Angina Pectoris
6	7	089	Simple Pneumonia and Pleurisy, Age Over 69 and/or Complicating Conditions
7	12	243	Medical Back Problems
8	13	138	Cardiac Arrhythmia and Conduction Disorders, Age Over 69 and/or Complicating Conditions
9	5	088	Chronic Obstructive Pulmonary Disease
10	21	296	Nutritional and Miscullaneous Metabolic Disorders, Age Over 69 and/or Complicating Conditions
11	15	015	Transient Ischemic Attacks
12	16	096	Bronchitis and Asthma, Age Over 69 and/or Complicating Conditions
13	25	336	Transurethral Prostatectomy, Age Over 69 and/or Complicating Conditions
14	26	209	Major Joint Procedures
15	9	122	Circulatory Disorders with Acute Myocardial Infarction, without Cardiovascular Complications, Discharged Alive
16	23	174	Gastrointestinal Hemorrhage
17	19	320	Kidney and Urinary Tract Infections, Age Over 69 and/or Complicating Conditions
18	10	294	Diabetes, Age Over 35
19	8	468	Unrelated Procedure
20	32	210	Hip and Femur Procedures Except Major Joint, Age Over 69 and/or Complicating Conditions
21	1/	121	Circulatory Disorders with Acute Myocardial Infarction and Cardiovascular Complications, Discharged Alive
22	18	082	Respiratory Neoplasms
23	38	148	Major Small and Large Bowel Procedures, Age Over 69 and/or Complicating Conditions
24	3	132	Atherosclerosis, Age Over 69 and/or Complicating Conditions
25	45	087	Pulmonary Edema and Respiratory Failure

1/ CY 81 rank not available because previously combined with DRG 122

(Source: Case-Mix Monitoring Tables using PATBILL records processed in BDMS through November 30, 1984)

Inpatient Hospital Benefit Payments, Total and PPS, October 1983 to Date

	Total Inpatient Benefit Payments		PPS Benefit Payments			
Month	Monthly	Cumulative	Monthly	Percent of Total	Cumulative	Percent of Total
		(in millions)				
			Fiscal Year 1984			
October	$2,963	$ 2,963	$ 190	6.4%	$ 190	6.4%
November	2,982	5,946	509	17.1	699	11.8
December	3,156	9,102	566	17.9	1,265	13.9
January	3,178	12,280	955	30.1	2,220	18.1
February	3,095	15,375	1,213	39.2	3,433	22.3
March	3,476	18,852	1,415	40.7	4,849	25.7
April	3,304	22,156	1,503	45.5	6,351	28.7
May	3,432	25,588	1,554	45.3	7,905	30.9
June	3,395	28,983	1,672	49.2	9,577	33.0
July	3,231	32,214	1,991	61.6	11,568	35.9
August	3,634	35,848	2,651	72.9	14,218	39.7
September	1,943	37,791	1,565	80.5	15,784	41.8
			Fiscal Year 1985			
October	$4,498	$ 4,498	$3,759	83.6%	$3,759	83.6%

Source: BPO - PPS Intermediary Benefit Payment Reports through October 1984.
Note: Benefit payments now include current year adjustments to PIP rates and end-of-fiscal-year retroactive adjustments. Excluded are $394 million in inpatient hospital benefits paid by Office of Direct Reimbursement through July 1984 for which monthly detail is not available. Relatively few benefits were paid by ODR under PPS.

PPS NATIONAL SUMMARY REPORT
FISCAL YEAR TO DATE
(10/3/83 - 09/30/84)

Hospitals on Prospective Payment: 5,405

	No. Paid	%	$ Paid	
PPS Bills	4,305,830		$ 13,927,472,057*	
Cost Outliers	20,585	0.5	$ 36,941,723	(only outlier payment)
Day Outliers	70,195	1.6	$ 115,196,745	(only outlier payment)

Distribution of Bills by Discharge Status

	No.	%		No	%
Total	4,305,830	100.0			
To Home, Self Care	3,477,264	80.8	To Other Facility	40,613	0.9
To Short Term Hospital	72,523**	1.7	To Home Health Service	130,261	3.0
To SNF	232,498	5.4	Against Medical Advice	9,615	0.2
To ICF	116,233	2.7	Died	226,823	5.3

Number of DRGs Needing Further Development:

Code	Total	%
DRG 468	50,957	1.2
DRG 469	264	
DRG 470	14,427	

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* Excludes pass through payments; includes outlier payments.

** Transfer dollars paid: $84,127,280

BPO/OPOP

Report of PPS Medical Review Activity

Admission Review

	October Data	Cumulative Data 10/1/83 - 10/31/84
Number of PPS Inpatient Hospital Admissions/Discharges	420,826	4,320,238
Total Admissions Reviewed for any Reason (including admission sample)	190,757	1,307,404
Percentage of PPS Inpatient Hospital Admissions Reviewed	45.3%	30.3%
Total Number of PPS Inpatient Hospital Admissions Denied	3,990	31,829
Percentage of PPS Inpatient Admissions Denied of Those Reviewed	2.1%	2.4%

Transfers

	October Data	Cumulative Data 10/1/83 - 10/31/84
Number of Psychiatric Unit Transfers Subjected to Medical Review	439	3,133
Number of Psychiatric Unit Transfers Denied	8	90
Percentage of Cases Denied	1.8%	2.9%
RO Referrals	11	70
Number of Rehabilitation Transfers Subjected to Medical Review	984	8,071
Number of Rehabilitation Transfers Denied	26	484
Percentage of Cases Denied	2.6%	6.0%
RO Referrals	0	25
Number of Alcohol/Drug Transfers Subjected to Medical Review	79	226
Number of Alcohol/Drug Transfers Denied	2	19

	October Data	Cumulative Data 10/1/83 - 10/31/84
Transfers - continued		
Percentage of Cases Denied	2.5%	8.4%
RO Referrals	0	4
Number of Swing Bed Transfers Subjected to Medical Review	471	2,471
Number of Swing Bed Transfers Denied	13	117
Percentage of Cases Denied	2.8%	4.7%
RO Referrals	2	30
Transfers From a PPS Hospital		
Number of Transfers from a PPS Hospital to any Other Hospital (PPS or Non-PPS) Reviewed	4,022	34,946
Number of Transfers Denied	45	789
Percentage of Cases Denied	1.1%	2.3%
RO Referrals	86	450
Admissions Within Seven Calendar Days of Discharge from a PPS Hospital		
Number of Admissions Within 7 Calendar Days of Discharge	11,558	109,617
Number Subjected to Medical Review	11,996	97,698
Number of Admissions Within 7 Calendar Days of Discharge Denied	528	3,784
Percentage of Admissions Denied of Those Reviewed	4.4%	3.9%
RO Referrals	155	1,402

	October Data	Cumulative Data 10/1/83 - 10/31/84
Procedure Review		
Number of Cases Involving Pacemaker Insertions Subjected to Medical Review	2,402	20,158
Number of Cases Involving Pacemaker Insertions Denied	47	305
Percentage of Pacemaker Insertions Denied	2.0%	1.5%
Number of Cases Involving Other Procedures Subjected to Medical Review	5,675	14,419
Number of Cases Involving Other Procedures Denied	153	332
Percentage of Cases Denied	2.7%	2.3%
RO Referrals	3	36

The number of procedures presently being reported reviewed continues to increase due to PRO review. Each PRO is required by contract to target review on specified elective procedure related DRGs or DRG groups where potential exists for inappropriate utilization or diminishing of quality of care in the area.

Review of Outliers	October Data	Cumulative Data 10/1/83 - 10/31/84
Number of Cases Approved in Day Outlier Category	6,406	54,078
Number of Days Approved as Day Outliers	86,697	760,374
Number of Days Denied as Day Outliers	8,494	90,329
Percentage of Day Outlier Days Denied	8.9%	10.6%
Number of Cases Approved as Cost Outliers	3,758	24,023
Amount of Charges Approved as Cost Outliers	$27,718,228	$175,370,112
Amount of Charges Denied as Cost Outliers	$ 994,677	$ 7,685,302
Percentage of Charges for Cost Outliers Denied	3.5%	4.2%

	October Data	Cumulative Data 10/1/83 - 10/30/84
DRG Validation		
Total Number of Random Sample Cases Reviewed	41,868	379,000
Number of Cases Reviewed for Other Reasons	58,330	475,654
Total Cases Reviewed (all DRG Validations)	100,198	854,654
Number of DRG Errors Identified that Resulted in a Change in DRG Assignment	5,335	

Admission Pattern Monitoring (APM)

NOTE: APM is in the process of being modified. No further activity will be reported until new instructions are issued in January 1985.

Medicare Short-Stay Hospital Admissions, Fiscal Year 1982 to Date
(through September 1984)

	FY 82	FY 83	FY 84	Percent Change	
	numbers in thousands1/			82-83	83-84
October	921	954	984	3.6	3.1
November	901	950	947	5.4	-0.3
December	866	903	891	4.3	-1.3
Total - First Quarter	2,688	2,807	2,822	4.4	0.5
January	943	1,052	1,044	11.6	-0.8
February	868	935	959	7.7	2.6
March	1,015	1,032	1,013	1.7	-1.8
Total - Second Quarter	2,826	3,019	3,016	6.8	-0.1
April	962	995	1,000	3.4	0.5
May	964	1,022	1,003	6.0	-1.9
June	958	976	929	1.9	-4.8
Total - Third Quarter	2,884	2,993	2,932	3.8	-2.0
July	931	953	934	2.4	-2.0
August	959	990	916	3.2	-7.5
September	932	934	875	0.2	-6.3
Total - Fourth Quarter	2,822	2,877	2,725	1.9	-5.3
Fiscal Year	11,220	11,696	11,495	4.2	-1.7*

* About 2.0 percent decrease if adjusted for Leap Year.

1/ Admissions October 1983 through September 1984 are projected to account for processing lags.

Source: Admission notices from Query/Reply System processed in BDMS through October 1984

DATA SOURCES

PPS Biweekly Summary Report - Selected summary data on PPS implementation reported to BPO by the Regional Offices who collect it from Intermediaries. Includes fairly current data for a limited number of items.

Medical Review Reports - Data on PPS admissions, denials, transfers, DRG validation, and outliers reported by Medical Review agents and compiled by HSQB. Includes fairly current data for a number of important PPS impact issues.

Intermediary Benefit Payment Report - Financial report on benefit payments under PPS reported by each Intermediary and compiled by BPO. Expected to be a fairly current and accurate source of benefit payment data.

Admission Notices - Admission counts can be tabulated based on notices of admission submitted each time a Medicare beneficiary enters a hospital. The notices are part of the query/reply system used to determine eligibility, deductible, and benefit status. Admission notices are less accurate than discharge bill records, but are more current. The following table can be used to judge the estimated completion levels for admission notice data:

	Completeness Level for a Month of Admission
End of Month	60-75%
One Month Later	98%
Two Months Later	99%

PATBILL Data - This is the most accurate source of information. It is derived from Medicare bill records as a by-product of administrative processing operations. The processing sequence from hospital to Intermediary to BSS to BDMS includes inherent lags which make the data base less current than workload reports and admission notices. The following table shows historical information on the levels of completeness for PATBILL files at specified periods of time:

Reported to HCFA Central Office	Month of Discharge	Quarter of Discharge	Year of Discharge
End of period	1-3%	42-60%	80-83%
1 month after	35-50%	65-72%	88-90%
2 months after	75-80%	85-90%	94-95%
3 months after	85-90%	91-94%	95-97%

Please note, however, that the flow of PATBILL records appears to have slowed considerably since PPS was implemented on October 1. For example, inpatient hospital bills processed in HCFA during October 1983 - September 1984 (11,446,161) are 10.6 percent lower than bills processed during October 1982 - September 1983 (12,804,108).

(4)

DRAFT

JAN 9 1985

NOTE TO: Tony Tirone (Director, Div. of Program Operations, Health Standards and Quality Bureau)
SUBJECT: Onsite Visit Reports - Update No. 1 (onsite visits of PROs)

A total of 48 initial onsite visit reports have been received from ROs. In addition, numerous reports of follow-up onsite visit reports and contract reports have been received. Some information has been received by telephone. The following ~~information~~ updates the December 13 summary of the results of the regional office evaluation of PRO implementation.

I. FI and Hospital Agreements

A. FIs

Thirty 30 ~~Twenty-nine~~ (29) PROs have signed final agreements with at least one of their fiscal intermediaries. Regional offices are keeping in close contact with PROs in this area and are involved in meetings to settle issues. The lack of a final agreement is not impeding review or notices of denial.

B. Hospitals

Twenty (20) ~~Eighteen~~ (18) PROs have final written agreements with hospitals in their areas. Hospitals are operating under interim or verbal agreements if there are no final written agreements. No region has reported problems with PROs obtaining access to the hospitals for review.

II. PATBILLS

Reports indicate that 38 PROs have received FI tapes but two-thirds have high error rates, erroneous formatting, poor interface between UHDDS and PATBILL, lack of certain elements being included, are unreadable, or have a very low number of claims being included. Areas involving edit problems should be resolved as FIs were to implement prepayment edits as of January 1, 1985. An update on the PATBILL status of PROs is now being prepared, and should be available soon.

III. Staffing

With the exception of Pennsylvania, all indications are that staffing of PRO organizations does not present ~~any~~ major problems at this time. Thirty-five PROs are staffing their offices timely and appropriately. 6 PROs are having minor difficulties hiring review RRAs, and/or ARTs with pertinent review and coding experience. Pennsylvania PRO is having problems hiring review coordinators and is only 50% staffed.

IV. Medical Review

A. Hospital Phase-In Schedule

Thirty-six (36) PROs report that their hospital phase-in schedule is on target. A few PROs are having problems as a result of PATBILL data not being received or being incorrect.

B. MR Process

Reports reflect that 28 PROs have established their medical review criteria sets. However, some of these sets are still being finalized from drafts or are undergoing revisions due to modifications being made to contract objectives. Those PROs (11) indicating problems with case review identification attribute their difficulties to the PATBILL problems discussed in Section II.

C. Medical Review

Nevada, Arizona, Louisiana and Florida continue to have implementation problems because of lack of PATBILL data. Regional offices are coordinating the resolution of these problems.

Nineteen (19) PROs report that some of their hospitals are under intensified review.

V. Data Processing

Pennsylvania is due to finalize their data subcontract shortly. Nine (9) PROs are processing their own data. Missouri terminated their contract with UTS and is doing their processing. Delaware was not able to reach agreement with their anticipated processor and will also be doing their own processing.

VI. Reporting Forms

Reports indicate that 26 PROs have implemented the reporting process and are capable of producing timely, accurate reports. Only 3 PROs report having difficulties in this area due to the PATBILL problem discussed in Section II.

VII. Other

Region VII reports that Iowa's system which focuses in on physicians rather than hospitals for preadmission or concurrent review is working well. If a physician falls outside the norm, he/she is put on preadmission review. Once on preadmission review for a quarter, the same physician has never shown up again in subsequent quarters. The region has noticed a reduction in admission patterns and days in general and will follow up to see if both these patterns continue.

Region VIII reports noticeable reductions in admissions and inpatient cataract surgery. They will be looking at subsequent quarters to verify this pattern.

VIII. Summary

PRO implementation is progressing smoothly, on schedule, and without major problems in most areas. FI and hospital agreements are being negotiated effectively. PRO operations and hospital phase-in schedules are generally on target. Medical review processes are progressing efficiently, with any difficulties being successfully resolved. Data processing and reporting, by and large underway, are constantly undergoing refinement.

The most predominant problem encountered by a number of PROs has to do with PATBILL data, specifically lack of receipt, high error rates, forms incompatibility, interface inability with PHDPS, low numbers of claims, lack of certain necessary elements or information, unreadable tapes, and other technical difficulties have resulted in delayed review implementation and requirements for contract objectives modifications. However, these situations are being successfully resolved on a case-by-case basis, and the recent issuance of transmittal 1181 (Medicare Intermediary Manual Part 3) providing specific guidance on handling PRO data should resolve these problems effectively and within the very near future.

Marvin Plunkett (Chief, Project
Assessment Branch, HSQB)

HSQB/OMR/DID/PAP/Dianne Coughlan/Diane Merriman/jl/1-9-85/2724A

NOTE TO: Phil Nathanson (Director, Health Standards and Quality Bureau, HCFA)

SUBJECT: Preadmission Review

PROs are required by contract to perform at least a minimum amount of preadmission review, estimated at 5.9 percent of admissions. Preadmission review is required for the review of five procedure-related DRGs. (Review of more than five procedures is expected for DRG groups where the average admission rate per thousand is above the national average.) While some PROs elected to keep their level of preadmission review to the minimum, the majority have opted for higher levels of preadmission review especially where admission reductions are expected. It should be noted that PROs have been instructed to report all PPS-related activity on the HCFA-516 (Report of PRO Medical Review Activity) and were instructed not to include admission and quality objective reviews on the form except where the objective overlaps with the HCFA-516 required activity. This was done to facilitate the continued reporting and analysis of PPS-related data. Our data would indicate some PROs are not maintaining this distinction.

Summary

Level of Preadmission Review

Attachment I is a table of the 47 PROs reporting PPS-related activity.

(The remaining seven PROs cover PPS-exempt and waivered States whose reporting mechanisms differ due to their unique review systems.) This table ranks these 47 PROs based on the estimated percent of preadmission review performed during the month of November together with the relevant denial percentage. The table also provides cummulative data.

- 18 of 47 PROs reported 5 percent or more of their estimated monthly admissions being reviewed during November and the majority of these PROs represent contracts in effect for four and five months.

- The remaining 29 PROs reported the following percentages of preadmission review for November:

2% to 4% = 6 PROs
1% to 2% = 6 PROs
.1% to .9% = 2 PROs
* 0% = 15 PROs

* Four of the 15 PROs reporting no preadmission review activity have been effective for four or five months and these are:

West Virginia	- PRO is performing preadmission review, however, it was not reported on the HCFA-516 due to computer program difficulties.
Colorado	- Preadmission review was just initiated on 11/1 and is included on the December's report.
Georgia	- Preadmission review implementation is scheduled for January 1.
Louisiana	- Preadmission review was implemented on 12/1/84.

The other PROs reporting no preadmission review include those effective for only one or two months. Prior to implementation of preadmission review system, criteria need to be developed and the hospital and physicians schooled on these criteria and advised of the specific cases to be subjected to preadmission review.

Preadmission Denials

The national average of preadmission review cases denied is 1.7 percent of those reviewed. Cumulatively (July through November), 1.4 percent of preadmission cases reviewed are denied. Following is a breakdown of PRO denial percentages for the montn of November as well as cumulatively:

November Only Denials

PROs with denial percentages above 1.7 percent = 11

PROs with denial percentage below 1.7 percent = 11

PROs reporting no denials (16 were effective for only 1/2 month to 2 months) = 25

Cumulative Denials

PROs with denial percentage above 1.4 percent = 10

PROs with denial percentages below 1.4 percent = 14

PROs reporting no denials = 23

Estimated Dollar Savings

Assuming PROs reported true preadmission denials (i.e., denial prior to admission), observing $2,907 as the average PPS reimbursement per bill and backing out those denials paid under waiver, where we know the patient nad to have been admitted to incur charges (i.e., preadmission review performed within 24 hours of admission or post-admission but pre-procedure), the monthly savings is estimated at $2 million and cumulatively estimated at $5.6 million.

Al Lazar (Director, Office of
Medical Review, HSQB, HCFA)

HCFA/HSQB/BPO/OMR/DAB/TDobahue mlh 1/18/85 #2825A

ATTACHMENT I

PRO	Estimated Monthly Admissions	No. of Months Effective	November Data % of Preadm. Review	November Data % Denial of Those Reviewed	Cumulative Data % of Preadm. Review	Cumulative Data % Denied of Those Reviewed
Kentucky	17,472	5	71.1	.08	69.4	.07
Minnesota	18,351	4	53.2	.2	45.8	.1
Alabama	20,015	5	39.5	.8	40.3	.8
Wisconsin	19,981	5	29.7	6.3	14.5	7.3
Tennessee	25,521	5	19.6	2.2	3.9	2.2
Indiana	21,679	4	11.2	5.9	5.8	4.4
Oregon	10,432	4	10.0	.05	5.0	.07
Nevada	2,852	5	9.7	2.9	5.6	4.0
New Mexico	3,932	4	9.2	0	4.0	.6
North Dakota	4,173	4	9.2	1.6	6.8	.9
Nebraska	8,779	2	8.5	0	4.3	0
New Hampshire	3,466	5	7.7	0	3.8	.3
Montana	3,357	5	7.3	0	2.5	0
Kansas	12,111	5	6.8	.1	6.0	.4
California	77,527	2	6.8	.3	3.4	.3
Arizona	10,549	4	6.6	5.5	4.5	6.4
Oklahoma	14,528	2	6.3	.2	3.1	.2
Wyoming	1,335	5	5.2	0	1.9	0
South Carolina	10,712	5	4.0	.2	2.1	.09

Iowa	14,533	5	3.8	4.2	3.4	3.1
North Carolina	23,084	4	3.7	22.7	1.8	25.3
Rhode Island	3,920	4	3.2	11.0	0.8	5.7
Ohio	43,954	2	2.7	0	1.3	0
Delaware	1,874	5	2.3	4.6	0.4	8.6
South Dakota	4,128	2	1.8	0	0.9	0
D.C.	2,679	1	1.6	0	1.6	0
Florida	61,131	4	1.5	.5	0.4	.5
Mississippi	11,933	5	1.4	0	1.0	0
Washington	14,791	2	1.4	.1	0.7	.1
Missouri	26,295	4	1.1	2.0	0.4	2.0
Utah	4,170	5	0.4	0	.08	0
Arkansas	14,371	5	0.3	2.2	1.0	.1
West Virginia	10,838	5	0	0	0	0
Georgia	23,021	4	0	0	0	0
Louisiana	17,294	4	0	0	0	0
Colorado	9,699	4	0	0	0	0
Pennsylvania	56,974	2	0	0	.02	0
Virginia	19,163	2	0	0	0	0
Michigan	35,297	2	0	0	0	0
Texas	58,977	2	0	0	0	0

			November Data		Cumulative Data	
PRO	Estimated Monthly Admissions	No. of Months Effective	% of Preadm. Review	% Denial of Those Received	% of Preadm. Review	% Denied of Those Reviewed
Maine	5,142	1	0	0	0	0
Connecticut	10,559	1	0	0	0	0
Vermont	2,086	1	0	0	0	0
Illinois	46,670	1	0	0	0	0
Idaho	3,628	1/2 Mo.	0	0	0	0
Alaska	410	1/2 Mo.	0	0	0	0
Hawaii (Review implementation begins in January)						
* 47 PROs			7.3	1.7	7.4	1.4
Monthly =	813,393		(59,553)	(1,039)	(188,313)	(2,541)
Cumulative =	(2,546,355)					

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* Excludes the seven PPS-exempt and waivered States. Their reporting mechanisms differ because of unique review systems.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Memorandum

Date Cum data through Nov 84

From Chairman
PPS Monitoring Committee

Subject Report on PPS Monitoring Activities -- January 20, 1985

To The Administrator

Highlights

- A total of 5,405 or 81 percent of all hospitals are on prospective payment.
- Total short-stay hospital admissions for FY 1984 (11.5 million) decreased slightly from the number reported for FY 1983 (11.7 million). Adjusted for leap year, this represents a 1.9 percent decrease in admissions. (Note: The final FY 1984 data may vary slightly, but will not be shown in subsequent reports.)
- There were an estimated 1.838 million short-stay hospital admissions in October - November 1984, down 4.8 percent from October - November 1983.
- Average length of stay per discharge for all Medicare short-stay hospital discharges (PPS and non-PPS) was 9.0 days in FY 1984, down from 10.0 days in FY 1983.

Benefit Payments

- Cumulative FY 1984 benefit payments under PPS were $15.8 billion through September 1984. This was 42 percent of all payments for inpatient hospital services reported this period.
- Cumulative FY 1985 benefit payments under PPS were $6.8 billion through November 1984. This was 83 percent of all payments for inpatient hospital services. Cumulative benefit payments include retroactive adjustments to PIP rates and accelerated payments.

  (Source: BPO-PPS Intermediary Benefit Payment Reports through November 1984)

Special PPS/non-PPS Facility Status

- The number of facilities given special consideration under PPS are: regional referral centers 70; cancer treatment centers 4; Mayo Clinics 6; sole community hospitals 302.

  (Source: BPO Implementation Report through December 1984)

Admissions

- The preliminary estimate of Medicare short-stay hospital admissions for FY 1984 is 11.5 million, a 1.6 percent decrease from the 11.7 million admissions recorded in FY 1983. Adjusted for leap year, this represents a 1.9 percent decrease. The revised estimate for all inpatient admissions (short-stay, long-stay, and excluded units) during FY 1984 is 11.7 million, down 0.8 percent from 11.8 million admissions in FY 1983. (Note: The final FY 1984 data may vary slightly, but will not be shown in subsequent reports.)

  (Source: Admission notices from Query/Reply System processed in BDMS through December 1984 and OFAA Actuarial estimates)

- A preliminary estimate of the number of Medicare short-stay hospital admissions during October - November 1984 is 1.838 million. This represents a decrease of 4.8 percent from October - November 1983.

  (Source: Admission notices from Query/Reply System processed in BDMS through December 1984.)

Admission Pattern Monitoring

- 1,446 hospitals were identified for review because of an increase in discharges during FY 1983. Thirty-one (31) percent had corrective action plans initiated, 54 percent required no additional action, and 15 percent are still being investigated.

  (Source: BDMS APM reports and Summary of HSQB Report of Medical Review Activity, September 1984)

- For the first three quarters of FY 1984 (October 1983 - June 1984) 1,322 hospitals were identified for review because of an increase in discharges.

  (Source: BDMS Quarterly APM Reports)

- HSQB plans to redirect the use of APM to a PRO performance monitoring device.

Case-Mix and DRG

- o The ten most frequently occurring DRGs reported for PPS discharges are:

FY 84 Rank	CY 81 Rank	DRG	Discharges	Percent of PPS
1	1	127 - Heart Failure and Shock	215,523	4.7
2	2	182 - Esophagitis, Gastroenteritis Miscellaneous Digestive Disorders, Age Over 69 and/or Complicating Conditions	171,192	3.7
3	4	039 - Lens Procedure	165,573	3.6
4	6	014- Specific Cerebrovascular Disorders Except Transient Ischemic Attacks	136,796	3.0
5	11	140 - Angina Pectoris	136,179	3.0
6	7	089 - Simple Pneumonia and Pleurisy, Age Over 69 and/or Complicating Conditions	134,138	2.9
7	12	243 - Medical Back Problems	92,235	2.0
8	13	138 - Cardiac Arrhythmia and Conduction Disorders, Age Over 69 and/or Complicating Conditions	90,922	2.0
9	5	088 - Chronic Obstructive Pulmonary Disease	89,979	2.0
10	21	296 - Nutritional and Miscellaneous Metabolic Disorders, Age Over 69 and/or Complicating Conditions	78,533	1.7

(Source: Case Mix monitoring tables using PATBILL records processed in BDMS through December 28, 1984)

- o DRG 468 cases were 1.2 percent of all reported PPS bills through September 30, 1984. These are undergoing further review.

  (Source: PPS monitoring tables using PATBILL records processed in BDMS through December 28, 1984)

- o Based on PATBILL records received to date, DRG 468 ranks 19th by frequency. The average reimbursement per discharge for DRG 468 (excluding passthrough payments) is $5,936 compared to $2,926 per discharge for all PPS bills.

  (Source: PPS monitoring tables using PATBILL records processed in BDMS through December 28, 1984)

- The case mix index for PPS bills through September 1984 was 1.1299 compared to 1.0534 in 1981, 7.7 percentage points higher.

  (Source: Case-Mix monitoring tables using PATBILL records processed in BDMS through December 28, 1984.)

Length of Stay

- Per Discharge

  Note: Until this month's report, the Length of Stay analysis was solely based on total days of care per bill. For PPS reimbursed stays, only one bill is reported for each stay. Therefore, total days of care as reported on the bill equal the total length of stay from day of admission to day of discharge. For non-PPS stays, one or more bills are possible (that is, interim and final bills). For this analysis, when more than one bill is reported for a stay they have been combined to obtain total length of stay per discharge. Comparisons are more appropriate when based on length of stay per discharge.

  Average length of stay per discharge for all short-stay hospitals (including PPS, non-PPS other than waiver States, and waiver States) was 9.0 days in FY 1984, down from 10.0 days in FY 1983.

  Average length of stay per discharge for all non-waiver State short-stay hospitals (including PPS and non-PPS) was 8.4 days in FY 1984, down from 9.5 days in FY 1983.

  Average length of stay per PPS discharge was 7.5 days in FY 1984. (Note: Average length of stay per PPS discharge is influenced by the geographic distribution of the phasein of PPS hospitals and by the slower reporting of more complex cases subject to review.)

  (Source: PPS monitoring tables using PATBILL records processed in BDMS through December 28, 1984.)

Average length of stay per discharge

	FY 1981	FY 1982	FY 1983	FY 1984
All short-stay hospitals	10.5	10.3	10.0	9.0
Non-waiver State short-stay hospitals	9.9	9.8	9.5	8.4
PPS	-	-	-	7.5
Non-PPS	-	-	-	9.4
Waiver State short-stay hospitals	13.8	13.5	13.1	12.5
Other area short-stay hospitals	9.7	9.5	9.1	8.6

Note: Data for FY 1984 are preliminary. Average length of stay per dischargefor PPS and non-PPS is influenced by the geographic distribution of the phasein of PPS hospitals during FY 1984 and by the slower reporting of more complex cases subject to review.

(Source: PPS monitoring tables using PATBILL records processed in BDMS through December 28, 1984.)

- Per Bill

Note: The following analysis is based on all bills, interim and final. For stays paid under PPS there is one bill for the stay. For non-PPS stays one or more bills are possible (that is, interim and final bills).

Based on PATBILL records received to date, the average number of days per bill for all hospitals (short-stay and long-stay) was 8.9 days during October 1983 - September 1984. The average days per bill for corresponding period in previous year (during October 1982 - September 1983) was 9.7. The corresponding averages for short-stay hospitals are 8.6 days (October 1983 - September 1984) and 9.4 days (October 1982 - September 1983).

(Source: PPS monitoring tables using PATBILL records processed in BDMS through December 28, 1984)

Outliers and Transfers (Discharge Destination)

Note: The BPO PPS Summary Report has been discontinued. Alternative sources for these data are being investigated.

Other Benefit Payments, Fiscal Year 1985

Benefit	Expenditures Reported ($ in millions)	Expenditures Projected ($ in millions)
Outpatient	$ 559	--
Hospital	447	--
Other	112	--
HHA	305	--
SNF	109	--
Distinct Part Units	92	--

Note: Monthly estimates of projected benefit payments by type of service are not yet available for FY 1985.

(Source: BPO-PPS Intermediary Benefit Payment Report through November 1984)

Medical Review Activity

Fifty-four PROs performed medical review during November. The data incorporated within this report is a consolidation of review activities reported by PROs and FIs responsible for completing cases indentified prior to PRO implementation.

- o PRO Review of DRG 468s (Excludes FI Activity)

  PROs reported 270 cases of DRG 468 changes in November, of which 54 cases increased to a higher relative weight value, 154 cases were reduced in relative weight value, and in 62 cases the revised DRG was not determined. One hundred thirty-eight of the cases changed to another surgical DRG and 70 of the cases changed to a medical DRG. The PROs in the Atlanta region reported the highest incidence of DRG-468 changes.

  For those DRG 468 cases adjusted to a higher relative weight value, the most common were as follows:

DRG	
148	Major small and large bowel procedures and/or c.c. (7 cases)
154	Stomach, Esophageal and Duodenal procedures and/or c.c. (6 cases)
209	Major joint procedures (4 cases)

For those adjusted to a lower relative weight value, the most common were:

336	Transurethral prostatectomy (10 cases)
127	Heart failure and shock (5 cases)
296	Nutritional Metabolic Disorders and/or c.c. (4 cases)

(Source: Summary of HSQB Report of PPS Medical Review Activity, November 1984)

- Admission Review

  FIs, and PROs reported 351,309 admissions/discharges during November. Total admissions reviewed were 186,371 (53.1 percent) and total denied 3,972 (2.1 percent). Cumulatively, 4,705,414 admissions/discharges were reported with 1,495,781 reviewed (31.8 percent) and 35,816 denied (2.4 percent).

  (Source: Summary of HSQB Report of PPS Medical Review Activity, November 1984)

- Transfers

  Psychiatric unit transfers reviewed in November total 342 cases with 10 denied (2.9 percent). Cumulatively, 3,485 cases have been reviewed with 100 denied (2.9 percent).

  Rehabilitation unit transfers reviewed in November total 938 cases with 43 denied (4.6 percent). Cumulatively, 9,020 cases have been reviewed with 527 denied (5.8 percent).

  Alcohol/drug treatment unit transfers reviewed in November total 59 cases with three denied (5.1 percent). Cumulatively, 285 cases have been reviewed with 22 denied (7.7 percent).

  Swing bed transfers reviewed in November total 722 cases with 50 denied (6.9 percent). Cumulatively, 3,202 cases have been reviewed with 168 denied (5.2 percent).

  (Source: Summary of HSQB Report of PPS Medical Review Activity, November 1984)

- Transfers From a PPS Hospital

  A total of 3,641 transfer cases were reviewed in November of which 50 were denied (1.4 percent). Cumulatively, 38,560 cases have been reviewed and 839 denied (2.2 percent).

  (Source: Summary of HSQB Report of PPS Medical Review Activity, November 1984)

- Readmissions Within 7 Calendar Days

  A total of 12,201 cases were identified in November of which 10,747 were reviewed and 344 denied (3.2 percent). Cumulatively, 122,021 readmissions have been reported with 107,689 reviewed and 3,970 denied (3.7 percent).

  (Source: Summary of HSQB Report of PPS Medical Review Activity, November 1984)

- Procedure Review

  Pacemaker insertions reviewed in November total 2,270 with 28 denied (1.2 percent). Cumulatively, 22,428 pacemaker insertions have been reviewed with 333 denied (1.5 percent).

  Other procedures subjected to medical review in November total 6,051 cases with 396 denied (6.5 percent). Cumulatively, 20,987 procedure related cases have been reviewed with 750 denied (3.6 percent).

  (Source: Summary of HSQB Report of PPS Medical Review Activity, November 1984)

- Review of Outliers

  Cases approved in the day outlier category in November were 5,541; the number of days approved were 98,576 and days denied were 7,506 (7.1 percent). Cumulatively, 59,626 cases have been approved as day outliers with 859,091 days approved and 98,517 days denied (10.3 percent).

  The most prevalent DRGs consistently reported as day outliers (both approved as well as denied) were:

  014: Specific cerebrovascular disorders except TIA
  127: Heart failure, shock
  468: Procedure unrelated to principal diagnosis

There were 2,958 cost outlier cases approved during November. A total of $1,175,820 was denied (6.2 percent) of the $19,011,871 reported outlier charges in excess of the DRG threshold. Cumulatively, 26,990 cases have been reported reviewed with 8.9 percent ($18.8 million) of cost outlier charges being denied of the total $212 million reported in excess of the DRG threshold.

The most prevalent DRGs consistently reported as cost outliers (both approved as well as denied) in November were:

106: Coronary Bypass wiyth Cardiac Cath
110: Major Reconstructive Vascular procedures
148: Major small and large bowel procedures

(Source: Summary of HSQB Report of PPS Medical Review Activity, November 1984)

- DRG Validation

Total cases reviewed in November for DRG validation were 106,623. Of these reviews, 4,479 (4.2 percent) resulted in a change in DRG assignment. Validations include 47,666 random sample cases and represent 13.6 percent of the 351,309 reported PPS admissions/discharges during November. The remaining 58,967 validations relate to cases under review for other reasons. Cumulatively, there have been 961,128 cases reviewed for DRG validation purposes.

(Source: Summary of HSQB Report of PPS Medical Review Activity, November 1984)

- Referrals to Regional Offices

This report includes the number and type of review cases referred to the regional offices (ROs) by PROs and FIs. These cases include certain transfers, readmissions within 7 days, and invasive procedures. Instructions to review entities require that ROs be provided a summary of cases where the reason for transfers is not apparent or was required by other than medical necessity; the readmission is covered yet the second stay is a result of a premature discharge; and pacemaker insertions and/or other invasive procedures where they appear inappropriate.

(Source: Summary of HSQB Report of PPS Medical Review Activity, November 1984)

Prospective Payment System Monitoring

Bill Analysis - PPS vs Non-PPS

	FY 84	
	Number of Bills	Amount Reimbursed(000)
All Inpatient Bills	10,940,214	$32,775,649
All PPS Bills	4,572,781	13,380,448
Non-PPS Bills	6,367,433	19,395,201
Short stay O/T waiver state	4,499,371	13,008,601
Waiver states	1,673,393	5,749,363
Psychiatric unit	33,077	123,841
Rehabilitation unit	16,021	96,137
All others[1]	145,571	417,259

[1] Includes long-stay hospitals.

Source: PATBILL records processed in BDMS through 12/28/84.

Prospective Payment System Monitoring

Length of Stay and Reimbursement - PPS vs Non-PPS

PPS Bills	FY 84
Number of Bills	4,572,781
Average Length of Stay Per Discharge	7.5
Average Reimbursement Per Discharge (excludes pass-throughs)	$ 2,926
Percent Reimbursement of Total Charges	71.4%
All Non-PPS Bills (Short-Stay and Long-Stay Hospital)	
Number of Bills	6,367,433
Average Days Per Bill	10.0
Average Reimbursement Per Bill	$ 3,046
Percent Reimbursement of Total Charges	61.5%
Non-PPS Bills (Short-Stay Hospital other than Excluded Units)	
Number of Bills	6,172,764
Average Days Per Bill	9.4
Average Reimbursement Per Bill	$ 3,039
Percent Reimbursement of Total Charges	61.8%

Source: PATBILL records processed in BDMS through 12/28/84

Prospective Payment System Monitoring DRG Analysis--PPS Bills
FY 84 to Date

FY 84 Rank	CY 81 Rank	DRG No.	Relative Cost Weight	Discharges	Percent	Average Length of Stay	Average Reimbursement per Discharge
Total				4,572,781	100.0	7.5	$2,926
1	1	127	1.0408	215,523	4.7	7.6	2,605
2	2	182	0.6185	171,192	3.7	5.4	1,355
3	4	039	0.5010	165,573	3.6	2.1	1,148
4	6	014	1.3527	136,796	3.0	9.8	3,383
5	11	140	0.7548	136,179	3.0	5.0	1,761
6	7	089	1.1029	134,138	2.9	8.4	2,598
7	12	243	0.7551	92,235	2.0	7.0	1,775
8	13	138	0.9297	90,922	2.0	5.5	2,275
9	5	088	1.0412	89,979	2.0	7.4	2,576
10	21	296	0.8979	78,533	1.7	6.8	2,215
11	15	015	0.6673	77,480	1.7	5.1	1,552
12	16	096	0.7996	76,624	1.7	6.6	1,827
13	25	336	1.0079	68,003	1.5	7.3	2,587
14	26	209	2.2912	65,798	1.4	14.3	6,310
15	9	122	1.3651	64,054	1.4	9.2	3,316
16	23	174	0.9281	63,986	1.4	6.5	2,263
17	19	320	0.8123	62,102	1.4	7.1	1,881
18	10	294	0.8087	59,290	1.3	7.2	1,948
19	8	468	2.1037	55,676	1.2	13.1	5,936
20	32	210	2.0833	50,616	1.1	14.5	5,522
21	1/	121	1.8648	48,746	1.1	11.4	4,743
22	18	082	1.1400	48,319	1.1	8.4	3,045
23	38	148	2.5493	44,691	1.0	15.9	7,084
24	3	132	0.9182	42,272	0.9	5.8	2,123
25	45	087	1.5529	40,619	0.9	8.9	4,097

1/ CY 81 rank not available because previously combined with DRG 122.

(Source: Case Mix monitoring tables using PATBILL records processed in BDMS through December 28, 1984)

Prospective Payment System Monitoring
DRG Analysis--PPS Bills
FY 84 to Date

FY 84 Rank	CY 81 Rank	DRG Number	Description
1	1	127	Heart Failure and Shock
2	2	182	Esophagitis, Gastroenteritis and Miscellaneous Digestive Disorders, Age Over 69 and/or Complicating Conditions
3	4	039	Lens Procedure
4	6	014	Specific Cerebrovascular Disorders Except Transient Ischemic Attacks
5	11	140	Angina Pectoris
6	7	089	Simple Pneumonia and Pleurisy, Age Over 69 and/or Complicating Conditions
7	12	243	Medical Back Problems
8	13	138	Cardiac Arrhythmia and Conduction Disorders, Age Over 69 and/or Complicating Conditions
9	5	088	Chronic Obstructive Pulmonary Disease
10	21	296	Nutritional and Miscellaneous Metabolic Disorders, Age Over 69 and/or Complicating Conditions
11	15	015	Transient Ischemic Attacks
12	16	096	Bronchitis and Asthma, Age Over 69 and/or Complicating Conditions
13	25	336	Transurethral Prostatectomy, Age Over 69 and/or Complicating Conditions
14	26	209	Major Joint Procedures
15	9	122	Circulatory Disorders with Acute Myocardial Infarction, without Cardiovascular Complications, Discharged Alive
16	23	174	Gastrointestinal Hemorrhage, Age Over 69 and/or Complicating Conditions
17	19	320	Kidney and Urinary Tract Infections, Age Over 69 and/or Complicating Conditions
18	10	294	Diabetes, Age Over 35
19	8	468	Unrelated Procedure
20	32	210	Hip and Femur Procedures Except Major Joint, Age Over 69 and/or Complicating Conditions
21	1/	121	Circulatory Disorders with Acute Myocardial Infarction and Cardiovascular Complications, Discharged Alive
22	18	082	Respiratory Neoplasms
23	38	148	Major Small and Large Bowel Procedures, Age Over 69 and/or Complicating Conditions
24	3	132	Atherosclerosis, Age Over 69 and/or Complicating Conditions
25	45	087	Pulmonary Edema and Respiratory Failure

1/ CY 81 rank not available because previously combined with DRG 122

(Source: Case-Mix monitoring tables using PATBILL records processed in BDMS through December 28, 1984)

Report of PPS Medical Review Activity

Admission Review

	November Data	Cumulative Data 10/1/83 - 11/30/84
Number of PPS Inpatient Hospital Admissions/Discharges	351,309	4,705,414
Total Admissions Reviewed for any Reason (including admission sample)	186,371	1,495,781
Percentage of PPS Inpatient Hospital Admissions Reviewed	53.1%	31.8%
Total Number of PPS Inpatient Hospital Admissions Denied	3,972	35,816
Percentage of PPS Inpatient Admissions Denied of Those Reviewed	2.1%	2.4%

Transfers

	November Data	Cumulative Data 10/1/83 - 11/30/84
Number of Psychiatric Unit Transfers Subjected to Medical Review	342	3,485
Number of Psychiatric Unit Transfers Denied	10	100
Percentage of Cases Denied	2.9%	2.9%
RO Referrals	3	73
Number of Rehabilitation Transfers Subjected to Medical Review	938	9,020
Number of Rehabilitation Transfers Denied	43	527
Percentage of Cases Denied	4.6%	5.8%
RO Referrals	4	29
Number of Alcohol/Drug Transfers Subjected to Medical Review	59	285
Number of Alcohol/Drug Transfers Denied	3	22

	November Data	Cumulative Data 10/1/83 - 11/30/84
Transfers - continued		
Percentage of Cases Denied	5.1%	7.7%
RO Referrals	0	4
Number of Swing Bed Transfers Subjected to Medical Review	722	3,202
Number of Swing Bed Transfers Denied	50	168
Percentage of Cases Denied	6.9%	5.2%
RO Referrals	0	30
Transfers From a PPS Hospital		
Number of Transfers from a PPS Hospital to any Other Hospital (PPS or Non-PPS) Reviewed	3,641	38,560
Number of Transfers Denied	50	839
Percentage of Cases Denied	1.4%	2.2%
RO Referrals	116	566
Readmissions Within Seven Calendar Days of Discharge from a PPS Hospital		
Number of Readmissions Within 7 Calendar Days of Discharge	12,201	122,021
Number Subjected to Medical Review	10,747	107,689
Number of Readmissions Within 7 Calendar Days of Discharge Denied	344	3,970
Percentage of Readmissions Denied of Those Reviewed	3.2%	3.7%
RO Referrals	288	1,690

Procedure Review

	November Data	Cumulative Data 10/1/83 - 11/30/84
Number of Cases Involving Pacemaker Insertions Subjected to Medical Review	2,270	22,428
Number of Cases Involving Pacemaker Insertions Denied	28	333
Percentage of Pacemaker Insertions Denied	1.2%	1.5%
Number of Cases Involving Other Procedures Subjected to Medical Review	6,051	20,987
Number of Cases Involving Other Procedures Denied	396	750
Percentage of Cases Denied	6.5%	3.6%
RO Referrals	* 439	463

The number of procedures presently being reported reviewed continues to increase due to PRO review. Each PRO is required by contract to target review on specified elective procedure related DRGs or DRG groups where potential exists for inappropriate utilization or diminishing of quality of care in the area.

* The Georgia PRO reported 438 cases reported to the RO and this figure is currently being investigated.

Review of Outliers

	November Data	Cumulative Data 10/1/83 - 11/30/84
Number of Cases Approved in Day Outlier Category	5,541	59,626
Number of Days Approved as Day Outliers	98,576	859,091
Number of Days Denied as Day Outliers	7,506	98,517
Percentage of Day Outlier Days Denied	7.1%	10.3%
Number of Cases Approved as Cost Outliers	2,958	26,990
Amount of Charges Approved as Cost Outliers	$17,836,051	$193,719,229
Amount of Charges Denied as Cost Outliers	$ 1,175,820	$ 18,877,489
Percentage of Charges for Cost Outliers Denied	6.2%	8.9%

	November Data	Cumulative Data 10/1/83 - 11/30/84
DRG Validation		
Total Number of Random Sample Cases Reviewed	47,666	426,109
Number of Cases Reviewed for Other Reasons	58,967	535,019
Total Cases Reviewed (all DRG Validations)	106,633	961,128
Number of DRG Errors Identified that Resulted in a Change in DRG Assignment	4,479	N/A

Admission Pattern Monitoring (APM)

NOTE: APM is in the process of being modified. No further activity will be reported until new instructions are issued.

Inpatient Hospital Benefit Payments, Total and PPS, October 1983 to Date

	Total Inpatient Benefit Payments		PPS Benefit Payments			
Month	Monthly	Cumulative	Monthly	Percent of Total	Cumulative	Percent of Total
		(in millions)				
			Fiscal Year 1984			
October	$2,963	$ 2,963	$ 190	6.4%	$ 190	6.4%
November	2,982	5,946	509	17.1	699	11.8
December	3,156	9,102	566	17.9	1,265	13.9
January	3,178	12,280	955	30.1	2,220	18.1
February	3,095	15,375	1,213	39.2	3,433	22.3
March	3,476	18,852	1,415	40.7	4,849	25.7
April	3,304	22,156	1,503	45.5	6,351	28.7
May	3,432	25,588	1,554	45.3	7,905	30.9
June	3,395	28,983	1,672	49.2	9,577	33.0
July	3,231	32,214	1,991	61.6	11,568	35.9
August	3,634	35,848	2,651	72.9	14,218	39.7
September	1,943	37,791	1,565	80.5	15,784	41.8
			Fiscal Year 1985			
October	$4,498	$ 4,498	$3,759	83.6%	$3,759	83.6%
November	3,621	8,119	3,012	83.2	6,771	83.4

Source: BPO - PPS Intermediary Benefit Payment Reports through November 1984.
Note: Benefit payments now include current year adjustments to PIP rates and end-of-fiscal-year retroactive adjustments. Excluded are $394 million in inpatient hospital benefits paid by Office of Direct Reimbursement through July 1984 for which monthly detail is not available. Relatively few benefits were paid by ODR under PPS.

Medicare Short-Stay Hospital Admissions, Fiscal Year 1982 to Date
(through November 1984)

	FY 82	FY 83	FY 84 1/	FY 85 1/	Percent Change 82-83	83-84	84-85
		numbers in thousands					
October	921	954	984	960	3.6	3.1	-2.4
November	901	950	946	878	5.4	-0.4	-7.2
December	866	903	891		4.3	-1.3	
Total - First Quarter	2,688	2,807	2,821		4.4	0.5	
January	943	1,052	1,044		11.6	-0.8	
February	868	935	959		7.7	2.6	
March	1,015	1,032	1,013		1.7	-1.8	
Total - Second Quarter	2,826	3,019	3,016		6.8	-0.1	
April	962	995	1,001		3.4	0.6	
May	964	1,022	1,004		6.0	-1.8	
June	958	976	931		1.9	-4.6	
Total - Third Quarter	2,884	2,993	2,936		3.8	-1.9	
July	931	953	935		2.4	-1.9	
August	959	990	917		3.2	-7.4	
September	932	934	872		0.2	-5.6	
Total - Fourth Quarter	2,822	2,877	2,734		1.9	-5.0	
Fiscal Year	11,220	11,696	11,507	1,838 2/	4.2	-1.6 3/	-4.8 4/

1/ Admissions for December 1983 through November 1984 are projected to account for processing lags.

2/ Year-to-date total.

3/ About 1.9 percent decrease if adjusted for Leap Year.

4/ Based on 1.930 million admissions for first 2 months of FY 1984.

Source: Admission notices from Query/Reply System processed in BDMS through December 1984

DATA SOURCES

PPS Biweekly Summary Report - Selected summary data on PPS implementation reported to BPO by the Regional Offices who collect it from Intermediaries. Includes fairly current data for a limited number of items.

Medical Review Reports - Data on PPS admissions, denials, transfers, DRG validation, and outliers reported by Medical Review agents and compiled by HSQB. Includes fairly current data for a number of important PPS impact issues.

Intermediary Benefit Payment Report - Financial report on benefit payments under PPS reported by each Intermediary and compiled by BPO. Expected to be a fairly current and accurate source of benefit payment data.

Admission Notices - Admission counts can be tabulated based on notices of admission submitted each time a Medicare beneficiary enters a hospital. The notices are part of the query/reply system used to determine eligibility, deductible, and benefit status. Admission notices are less accurate than discharge bill records, but are more current. The following table can be used to judge the estimated completion levels for admission notice data:

	Completeness Level for a Month of Admission
End of Month	60-75%
One Month Later	98%
Two Months Later	99%

PATBILL Data - This is the most accurate source of information. It is derived from Medicare bill records as a by-product of administrative processing operations. The processing sequence from hospital to Intermediary to BSS to BDMS includes inherent lags which make the data base less current than workload reports and admission notices. The following table shows historical information on the levels of completeness for PATBILL files at specified periods of time:

Reported to HCFA Central Office	Month of Discharge	Quarter of Discharge	Year of Discharge
End of period	1-3%	42-60%	80-83%
1 month after	35-50%	65-72%	88-90%
2 months after	75-80%	85-90%	94-95%
3 months after	85-90%	91-94%	95-97%

Please note, however, that the flow of PATBILL records appears to have slowed considerably since PPS was implemented on October 1. For example, inpatient hospital bills processed in HCFA during October 1983 - September 1984 (11,446,161) are 10.6 percent lower than bills processed during October 1982 - September 1983 (12,804,108).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Memorandum

IG
DIG
AIG-A
AIG-HFI
AIG-I
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PA
CLO
ADM
OGC/IG
EX SEC
DATE SENT 3/6

Nelson Stone

Date MAR 1 1985

From James L. Scott
Chairman
PPS Monitoring Committee

Subject Report on PPS Monitoring Activities — February 20, 1985

To The Administrator

Highlights

- o A total of 5,405 or 81 percent of all hospitals are on prospective payment.
- o There were an estimated 2.701 million short-stay hospital admissions during October - December 1984, down 4.3 percent from October - December 1983.
- o Average length of stay per discharge for all Medicare short-stay hospital discharges (PPS and non-PPS) was 9.0 days in FY 1984, down from 10.0 days in FY 1983.

Benefit Payments

- o Cumulative FY 1985 benefit payments under PPS were $9.6 billion through December 1984. This was 83 percent of all payments for inpatient hospital services. Cumulative benefit payments include retroactive adjustments to PIP rates and accelerated payments.

  (Source: BPO-PPS Intermediary Benefit Payment Reports through December 1984)

Special PPS/non-PPS Facility Status

- o The number of facilities given special consideration under PPS are: regional referral centers 94; cancer treatment centers 4; Mayo Clinics 6; sole community hospitals 303.

  (Source: BPO Implementation Report through January 1985)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Tom —

See page 22 (Please note that the figures as presented include data obtained before PRO's were effective. Oct 1, 1983 was used as a start date because that was when PPS started

Date MAR 1 1985

James L. Scott.

From Chairman
PPS Monitoring Committee

Subject Report on PPS Monitoring Activities — February 20,

To The Administrator

Highlights

- o A total of 5,405 or 81 percent of all payment.
- o There were an estimated 2.701 million during October - December 1984, down December 1983.
- o Average length of stay per discharge hospital discharges (PPS and non-PPS) was 9.0 days in FY 1984, down from 10.0 days in FY 1983.

Benefit Payments

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  (Source: BPO-PPS Intermediary Benefit Payment Reports through December 1984)

Special PPS/non-PPS Facility Status

- o The number of facilities given special consideration under PPS are: regional referral centers 94; cancer treatment centers 4; Mayo Clinics 6; sole community hospitals 303.

  (Source: BPO Implementation Report through January 1985)

- The number of hospitals and units excluded from PPS are:

PPS Exclusions

Exclusion Category	FY 1984 Approvals	FY 1985 Year-to-Date (1/31/85) Reverification Approvals	FY 1985 Year-to-Date (1/31/85) Reverification Denials	FY 1985 Year-to-Date (1/31/85) Initial Approvals	Current Number of Exclusions (1/31/85)
Hospitals					
Psychiatric	439	-	2	13	450
Rehabilitation	49	9	-	-	49
Alcohol/Drug	25	1	-	3	28
Long-Term	84	38	-	-	84
Children's	47	7	-	-	47
Units					
Psychiatric	722	215	8	38	752
Rehabilitation	308	94	2	37	343
Alcohol/Drug	220	56	-	55	275

(Source: HSQB Report of PPS Exclusion Activity, January 31, 1985)

Admissions

- A preliminary estimate of the number of Medicare short-stay hospital admissions during October - December 1984 is 2.701 million. This represents a decrease of 4.3 percent from October - December 1983. Total Medicare inpatient hospital admissions (short-stay, long-stay, and excluded units) are projected to increase 1.2 percent during FY 1985 over FY 1984 levels.

  (Source: Admission notices from Query/Reply System processed in BDMS through January 1985 and OFAA actuarial estimates.)

Admission Pattern Monitoring

- 1,446 hospitals were identified for review because of an increase in discharges during FY 1983. Thirty-one (31) percent had corrective action plans initiated, 54 percent required no additional action, and 15 percent are still being investigated.

  (Source: BDMS APM reports and Summary of HSQB Report of Medical Review Activity, September 1984)

- For the first three quarters of FY 1984 (October 1983 - June 1984) 1,322 hospitals were identified for review because of an increase in discharges.

  (Source: BDMS Quarterly APM Reports)

- HSQB plans to redirect the use of APM to a PRO performance monitoring device.

PATBILL Data

For the next several reports, statistics dependent on PATBILL records, i.e., Case-Mix, DRG, and Length of Stay analyses, will be shown for both FY 1984 and FY 1985. When the FY 1984 data appear stable, they will be labeled final and will no longer be shown in the monthly report. Note that data for FY 1985 are preliminary and may be affected by the slower reporting of more complex cases.

Case-Mix and DRG - Fiscal Year 1984

- The ten most frequently occurring DRGs reported for PPS discharges during FY 1984 are:

FY 84 Rank	CY 81 Rank	DRG	Discharges	Percent of PPS
1	1	127 - Heart Failure and Shock	220,246	4.7
2	2	182 - Esophagitis, Gastroenteritis Miscellaneous Digestive Disorders, Age Over 69 and/or Complicating Conditions	174,933	3.7
3	4	039 - Lens Procedure	168,117	3.6
4	6	014- Specific Cerebrovascular Disorders Except Transient Ischemic Attacks	140,058	3.0
5	11	140 - Angina Pectoris	139,367	3.0
6	7	089 - Simple Pneumonia and Pleurisy, Age Over 69 and/or Complicating Conditions	136,575	2.9
7	12	243 - Medical Back Problems	94,313	2.0
8	13	138 - Cardiac Arrhythmia and Conduction Disorders, Age Over 69 and/or Complicating Conditions	93,017	2.0
9	5	088 - Chronic Obstructive Pulmonary Disease	91,866	2.0
10	21	296 - Nutritional and Miscellaneous Metabolic Disorders, Age Over 69 and/or Complicating Conditions	80,713	1.7

(Source: Case Mix monitoring tables using PATBILL records processed in BDMS through January 25, 1985)

- DRG 468 cases were 1.2 percent of all reported FY 1984 PPS bills received to date. These are undergoing further review.

  (Source: PPS monitoring tables using PATBILL records processed in BDMS through January 25, 1985)

- Based on FY 1984 PATBILL records received to date, DRG 468 ranks 19th by frequency. The average reimbursement per discharge for DRG 468 (excluding passthrough payments) is $5,947 compared to $2,937 per discharge for all PPS bills.

  (Source: PPS monitoring tables using PATBILL records processed in BDMS through January 25, 1985)

- The case mix index for PPS bills through September 1984 was 1.1317 compared to 1.0534 in 1981, 7.8 percentage points higher.

  (Source: Case-Mix monitoring tables using PATBILL records processed in BDMS through January 25, 1985)

Length of Stay - Fiscal Year 1984

- Per Discharge

  Note: Until January's report, the Length of Stay analysis was solely based on total days of care per bill. For PPS reimbursed stays, only one bill is reported for each stay. Therefore, total days of care as reported on the bill equal the total length of stay from day of admission to day of discharge. For non-PPS stays, one or more bills are possible (that is, interim and final bills). For this analysis, when more than one bill is reported for a stay they have been combined to obtain total length of stay per discharge. Comparisons are more appropriate when based on length of stay per discharge.

  Average length of stay per discharge for all short-stay hospitals (including PPS, non-PPS other than waiver States, and waiver States) was 9.0 days in FY 1984, down from 10.0 days in FY 1983.

  Average length of stay per discharge for all non-waiver State short-stay hospitals (including PPS and non-PPS) was 8.4 days in FY 1984, down from 9.5 days in FY 1983.

  Average length of stay per PPS discharge was 7.5 days in FY 1984. (Note: Average length of stay per PPS discharge is influenced by the geographic distribution of the phasein of PPS hospitals and by the slower reporting of more complex cases subject to review.)

  (Source: PPS monitoring tables using PATBILL records processed in BDMS through January 25, 1985)

Average length of stay per discharge

	FY 1981	FY 1982	FY 1983	FY 1984
All short-stay hospitals	10.5	10.3	10.0	9.0
Non-waiver State short-stay hospitals	9.9	9.8	9.5	8.4
PPS	-	-	-	7.5
Non-PPS	-	-	-	9.4
Waiver State short-stay hospitals	13.8	13.5	13.1	12.5
Other area short-stay hospitals	9.7	9.5	9.1	8.6

Note: Data for FY 1984 are preliminary. Average length of stay per discharge for PPS and non-PPS is influenced by the geographic distribution of the phasein of PPS hospitals during FY 1984 and by the slower reporting of more complex cases subject to review.

(Source: PPS monitoring tables using PATBILL records processed in BDMS through January 25, 1985)

- Per Bill

Note: The following analysis is based on all bills, interim and final. For stays paid under PPS there is one bill for the stay. For non-PPS stays one or more bills are possible (that is, interim and final bills).

Based on PATBILL records received to date, the average number of days per bill for all hospitals (short-stay and long-stay) was 8.9 days during October 1983 - September 1984. The average days per bill for corresponding period in previous year (during October 1982 - September 1983) was 9.7. The corresponding averages for short-stay hospitals are 8.6 days (October 1983 - September 1984) and 9.4 days (October 1982 - September 1983).

(Source: PPS monitoring tables using PATBILL records processed in BDMS through January 25, 1985)

Case-Mix and DRG - Fiscal Year 1985

- o The ten most frequently occurring DRGs reported to date for PPS discharges during FY 1985 are:

FY 85 Rank	FY 84 Rank	DRG	Discharges	Percent of PPS
1	1	127 - Heart Failure and Shock	43,461	4.9
2	5	140 - Angina Pectoris	31,055	3.5
3	2	182 - Esophagitis, Gastroenteritis Miscellaneous Digestive Disorders, Age Over 69 and/or Complicating Conditions	30,945	3.5
4	4	014- Specific Cerebrovascular Disorders Except Transient Ischemic Attacks	27,856	3.1
5	3	039 - Lens Procedure	27,468	3.1
6	6	089 - Simple Pneumonia and Pleurisy, Age Over 69 and/or Complicating Conditions	25,059	2.8
7	8	138 - Cardiac Arrhythmia and Conduction Disorders, Age Over 69 and/or Complicating Conditions	19,525	2.2
8	7	243 - Medical Back Problems	17,504	2.0
9	14	209 - Major Joint Procedures	16,917	1.9
10	11	015 - Transient Ischemic Attacks	16,427	1.8

(Source: Case Mix monitoring tables using PATBILL records processed in BDMS through January 25, 1985)

- o DRG 468 cases were 0.9 percent of all FY 1985 PPS bills processed through January 25, 1985. These are undergoing further review.

  (Source: PPS monitoring tables using PATBILL records processed in BDMS through January 25, 1985)

- o Based on FY 1985 PATBILL records received to date, DRG 468 ranks 26th by frequency. The average reimbursement per discharge for DRG 468 (excluding passthrough payments) is $6,207 compared to $3,144 per discharge for all PPS bills.

  (Source: PPS monitoring tables using PATBILL records processed in BDMS through January 25, 1985)

- o The case mix index for FY 1985 PPS bills processed through January 25, 1985 was 1.1368 compared to 1.1317 during all FY 1984, 0.5 percentage points higher.

  (Source: Case-Mix monitoring tables using PATBILL records processed in BDMS through January 25, 1985)

Length of Stay - Fiscal Year 1985

- Per Bill

  Note: The following analysis is based on all bills, interim and final. For stays paid under PPS there is one bill for the stay. For non-PPS stays one or more bills are possible (that is, interim and final bills). Data for FY 1985 are preliminary and may be affected by the slower reporting of more complex cases.

  Based on PATBILL records received to date, primarily for discharges during October - November 1984, the average number of days per bill for all hospitals (short-stay and long-stay) was 8.1 days. The average days per bill for corresponding period in previous year (during October 1982 - November 1983) was 9.3. The corresponding averages for short-stay hospitals are 8.6 days (October - November 1984) and 8.9 days (October - November 1983).

  For the first 2 months of FY 1985, the average number of days of care per PPS bill was 7.3 days.

  (Source: PPS monitoring tables using PATBILL records processed in BDMS through January 25, 1985)

Outliers and Transfers (Discharge Destination)

Note: The BPO PPS Summary Report has been discontinued. Alternative sources for these data are being investigated.

Benefit Payments, Fiscal Year 1985

- Total inpatient hospital (PPS and non-PPS) benefit payments were 1 percent higher than projected. Benefits paid under PPS were 5 percent higher than projected. Outpatient hospital benefits were 20 percent lower than projected, HHA benefits 17 percent lower than projected, and SNF benefits 8 percent higher than projected.

Benefit	Expenditures Reported	Expenditures Projected	Reported As % of Projected
	($ in millions)		
All Inpatient Hospitals	$11,567	$11,456	101%
PPS	9,600	9,147	105
Outpatient	856	1,069	80
Hospital	691	--	--
Other	165	--	--
HHA	455	545	83
SNF	160	148	108
Distinct Part Units	139	--	--

(Source: BPO-PPS Intermediary Benefit Payment Report through December 1984 and OFAA actuarial estimates)

Medical Review Activity

Fifty-four PROs performed medical review during December. The data incorporated within this report are a consolidation of review activities reported by PROs and FIs. FIs are responsible for completing their review of cases identified prior to PRO implementation.

- PRO Review of DRG 468s (Excludes FI Activity)

  PROs reported 322 cases of DRG 468 changes in December, of which 58 cases increased to a higher relative weight value, 200 cases were reduced in relative weight value, and in 64 cases the revised DRG was not determined. One hundred seventy-four (174) of the cases changed to another surgical DRG and 84 of the cases changed to a medical DRG.

  For those DRG 468 cases adjusted to a higher relative weight value, the most common were as follows:

DRG 154	Stomach, Esophageal and Duodenal procedures and/or c.c. (11 cases)
415	O.R. procedure for infections and parasitic diseases (7 cases)
148	Major small and large bowel procedures and/or c.c. (5 cases)

  For those adjusted to a lower relative weight value, the most common were:

DRG 039	Lens Procedures (9 cases)
336	Transurethral prostatectomy (8 cases)
197	Total Cholecystectomy w/o C.D.E. (7 cases)

  (Source: Summary of HSQB Report of PPS Medical Review Activity, December 1984)

- Admission Review

  FIs, and PROs reported 637,976 admissions/discharges during December. Total admissions reviewed were 213,676 (33.5 percent) and total denied 4,701 (2.2 percent). Cumulatively, 5,344,956 admissions/discharges were reported with 1,732,484 reviewed (32.4 percent) and 40,715 denied (2.4 percent).

  (Source: Summary of HSQB Report of PPS Medical Review Activity, December 1984)

- Transfers

  Psychiatric unit transfers reviewed in December total 322 cases with 18 denied (6.0 percent). Cumulatively, 3,815 cases have been reviewed with 120 denied (3.1 percent).

Rehabilitation unit transfers reviewed in December total 880 cases with 36 denied (4.1 percent). Cumulatively, 9,907 cases have been reviewed with 563 denied (5.7 percent).

Alcohol/drug treatment unit transfers reviewed in December total 28 cases with zero denied. Cumulatively, 311 cases have been reviewed with 22 denied (7.1 percent).

Swing bed transfers reviewed in December total 637 cases with 32 denied (5.0 percent). Cumulatively, 3,839 cases have been reviewed with 202 denied (5.3 percent).

(Source: Summary of HSQB Report of PPS Medical Review Activity, December 1984)

- Transfers From a PPS Hospital

A total of 3,677 transfer cases were reviewed in December of which 42 were denied (1.1 percent). Cumulatively, 42,340 cases have been reviewed and 883 denied (2.1 percent).

(Source: Summary of HSQB Report of PPS Medical Review Activity, December 1984)

- Readmissions Within 7 Calendar Days

A total of 17,566 cases were identified in December of which 9,724 were reviewed and 266 denied (2.7 percent). Cumulatively, 140,646 readmissions have been reported with 118,265 reviewed and 4,234 denied (3.6 percent).

(Source: Summary of HSQB Report of PPS Medical Review Activity, December 1984)

- Procedure Review

Pacemaker insertions reviewed in December total 2,585 with 39 denied (1.5 percent). Cumulatively, 26,744 pacemaker insertions have been reviewed with 372 denied (1.4 percent).

Other procedures subjected to medical review in December total 6,256 cases with 111 denied (1.8 percent). Cumulatively, 28,934 procedure related cases have been reviewed with 832 denied (2.9 percent).

(Source: Summary of HSQB Report of PPS Medical Review Activity, December 1984)

- Review of Outliers

Cases approved in the day outlier category in December were 5,330; the number of days approved were 72,910 and days denied were 6,986 (8.7 percent). Cumulatively, 64,808 cases have been approved as day outliers with 915,355 days approved and 105,502 days denied (10.3 percent).

The most prevalent DRGs consistently reported as day outliers (both approved as well as denied) were:

DRG 014: Specific cerebrovascular disorders except TIA
468: Procedure unrelated to principal diagnosis
430: Psychoses

There were 2,951 cost outlier cases approved during December. A total of $1,571,434 was denied (5.1 percent) of the $30,812,195 reported outlier charges in excess of the DRG threshold. Cumulatively, 29,822 cases have been reported approved with 4.5 percent ($10.4 million) of cost outlier charges being denied of the total $233 million reported in excess of the DRG threshold.

The most prevalent DRGs consistently reported as cost outliers (both approved as well as denied) in December were:

DRG 106: Coronary Bypass with Cardiac Cath
079: Respiratory infections and inflammations
148: Major small and large bowel procedures

(Source: Summary of HSQB Report of PPS Medical Review Activity, December 1984)

- DRG Validation

Total cases reviewed in December for DRG validation were 119,841. Of these reviews, 4,761 (4.0 percent) resulted in a change in DRG assignment. Validations include 41,662 random sample cases and represent 6.5 percent of the 637,976 reported PPS admissions/discharges during December. The remaining 78,179 validations relate to cases under review for other reasons. Cumulatively, there have been 1,084,056 cases reviewed for DRG validation purposes.

(Source: Summary of HSQB Report of PPS Medical Review Activity, December 1984)

- Referrals to Regional Offices

  This report includes the number and type of review cases referred to the regional offices (ROs) by PROs and FIs. These cases include certain transfers, readmissions within 7 days, and invasive procedures. Instructions to review entities require that ROs be provided a summary of cases where the reason for transfers is not apparent or was required by other than medical necessity; the readmission is covered yet the second stay is a result of a premature discharge; and pacemaker insertions and/or other invasive procedures where they appear inappropriate.

  An analysis of cases referred to us to date indicates that premature discharges, unnecessary transfers, and unjustified readmissions are occurring. We have, therefore, developed a policy which would require denials where the PRO encounters such cases. That policy is in the HCFA clearance process and should be issued shortly.

  (Source: Summary of HSQB Report of PPS Medical Review Activity, December 1984)

Prospective Payment System Monitoring

Bill Analysis - PPS vs Non-PPS

	FY 84	
	Number of Bills	Amount Reimbursed(000)
All Inpatient Bills	11,100,754	$33,310,213
All PPS Bills	4,683,580	13,753,632
Non-PPS Bills	6,417,174	19,556,581
Short stay O/T waiver state	4,520,442	13,068,804
Waiver states	1,694,469	5,825,969
Psychiatric unit	34,756	130,053
Rehabilitation unit	16,947	101,813
All others[1]	150,560	429,942

[1] Includes long-stay hospitals.

Source: PATBILL records processed in BDMS through 1/25/85

Prospective Payment System Monitoring

Length of Stay and Reimbursement - PPS vs Non-PPS

PPS Bills	FY 84
Number of Bills	4,683,580
Average Length of Stay Per Discharge	7.5
Average Reimbursement Per Discharge (excludes pass-throughs)	$ 2,937
Percent Reimbursement of Total Charges	71.2%
All Non-PPS Bills (Short-Stay and Long-Stay Hospital)	
Number of Bills	6,417,174
Average Days Per Bill	10.0
Average Reimbursement Per Bill	$ 3,048
Percent Reimbursement of Total Charges	61.5%
Non-PPS Bills (Short-Stay Hospital other than Excluded Units)	
Number of Bills	6,214,911
Average Days Per Bill	9.4
Average Reimbursement Per Bill	$ 3,040
Percent Reimbursement of Total Charges	61.8%

Source: PATBILL records processed in BDMS through 1/25/85

Prospective Payment System Monitoring

Bill Analysis - PPS vs Non-PPS

	FY 85 Year-to-Date	
	Number of Bills	Amount Reimbursed(000)
All Inpatient Bills	1,090,964	$ 3,515,103
All PPS Bills	892,137	2,804,595
Non-PPS Bills	198,827	710,508
Short stay O/T waiver state	17,341	55,077
Waiver states	162,974	576,776
Psychiatric unit	6,484	25,555
Rehabilitation unit	2,733	18,607
All others[1]	9,295	34,494

[1] Includes long-stay hospitals.

Source: PATBILL records processed in BDMS through 1/25/85

Prospective Payment System Monitoring

Length of Stay and Reimbursement - PPS vs Non-PPS

PPS Bills	FY 85 Year-to-Date
Number of Bills	892,137
Average Length of Stay Per Discharge	7.3
Average Reimbursement Per Discharge (excludes pass-throughs)	$ 3,144
Percent Reimbursement of Total Charges	72.2%
All Non-PPS Bills (Short-Stay and Long-Stay Hospital)	
Number of Bills	198,827
Average Days Per Bill	11.8
Average Reimbursement Per Bill	$ 3,573
Percent Reimbursement of Total Charges	70.1%
Non-PPS Bills (Short-Stay Hospital other than Excluded Units)	
Number of Bills	180,315
Average Days Per Bill	10.9
Average Reimbursement Per Bill	$ 3,504
Percent Reimbursement of Total Charges	71.1%

Source: PATBILL records processed in BDMS through 1/25/85

Prospective Payment System Monitoring DRG Analysis--PPS Bills
FY 84

FY 84 Rank	CY 81 Rank	DRG No.	Relative Cost Weight	Discharges	Percent	Average Length of Stay	Average Reimbursement per Discharge
Total				4,683,580	100.0	7.5	$2,937
1	1	127	1.0408	220,246	4.7	7.6	2,610
2	2	182	0.6185	174,933	3.7	5.4	1,357
3	4	039	0.5010	168,117	3.6	2.1	1,150
4	6	014	1.3527	140,058	3.0	9.8	3,388
5	11	140	0.7548	139,367	3.0	5.0	1,763
6	7	089	1.1029	136,575	2.9	8.4	2,602
7	12	243	0.7551	94,313	2.0	7.0	1,776
8	13	138	0.9297	93,017	2.0	5.5	2,280
9	5	088	1.0412	91,866	2.0	7.4	2,580
10	21	296	0.8979	80,713	1.7	6.9	2,219
11	15	015	0.6673	79,165	1.7	5.1	1,554
12	16	096	0.7996	78,048	1.7	6.6	1,831
13	25	336	1.0079	69,493	1.5	7.3	2,590
14	26	209	2.2912	67,405	1.4	14.3	6,317
15	23	174	0.9281	65,669	1.4	6.6	2,267
16	9	122	1.3651	65,457	1.4	9.2	3,320
17	19	320	0.8123	63,605	1.4	7.1	1,885
18	10	294	0.8087	60,558	1.3	7.2	1,951
19	8	468	2.1037	57,862	1.2	13.1	5,947
20	32	210	2.0833	51,823	1.1	14.5	5,528
21	1/	121	1.8648	49,893	1.1	11.4	4,749
22	18	082	1.1400	49,682	1.1	8.4	3,052
23	30	148	2.5493	46,042	1.0	16.0	7,097
24	3	132	0.9182	43,039	0.9	5.8	2,126
25	45	087	1.5529	41,638	0.9	8.9	4,104

1/ CY 81 rank not available because previously combined with DRG 122.

(Source: Case Mix monitoring tables using PATBILL records processed in BDMS through January 25, 1985)

Prospective Payment System Monitoring
DRG Analysis--PPS Bills
FY 84 to Date

FY 84 Rank	CY 81 Rank	DRG Number	Description
1	1	127	Heart Failure and Shock
2	2	182	Esophagitis, Gastroenteritis and Miscellaneous Digestive Disorders, Age Over 69 and/or Complicating Conditions
3	4	039	Lens Procedure
4	6	014	Specific Cerebrovascular Disorders Except Transient Ischemic Attacks
5	11	140	Angina Pectoris
6	7	089	Simple Pneumonia and Pleurisy, Age Over 69 and/or Complicating Conditions
7	12	243	Medical Back Problems
8	13	138	Cardiac Arrhythmia and Conduction Disorders, Age Over 69 and/or Complicating Conditions
9	5	088	Chronic Obstructive Pulmonary Disease
10	21	296	Nutritional and Miscellaneous Metabolic Disorders, Age Over 69 and/or Complicating Conditions
11	15	015	Transient Ischemic Attacks
12	16	096	Bronchitis and Asthma, Age Over 69 and/or Complicating Conditions
13	25	336	Transurethral Prostatectomy, Age Over 69 and/or Complicating Conditions
14	26	209	Major Joint Procedures
15	23	174	Gastrointestinal Hemorrhage, Age Over 69 and/or Complicating Conditions
16	9	122	Circulatory Disorders with Acute Myocardial Infarction, without Cardiovascular Complications, Discharged Alive
17	19	320	Kidney and Urinary Tract Infections, Age Over 69 and/or Complicating Conditions
18	10	294	Diabetes, Age Over 35
19	8	468	Unrelated Procedure
20	32	210	Hip and Femur Procedures Except Major Joint, Age Over 69 and/or Complicating Conditions
21	1/	121	Circulatory Disorders with Acute Myocardial Infarction and Cardiovascular Complications, Discharged Alive
22	18	082	Respiratory Neoplasms
23	38	148	Major Small and Large Bowel Procedures, Age Over 69 and/or Complicating Condition
24	3	132	Atherosclerosis, Age Over 69 and/or Complicating Conditions
25	45	087	Pulmonary Edema and Respiratory Failure

1/ CY 81 rank not available because previously combined with DRG 122

(Source: Case-Mix monitoring tables using PATBILL records processed in BDMS through January 25, 1985)

Prospective Payment System Monitoring DRG Analysis--PPS Bills
FY 85 to Date

FY 85 Rank	FY 84 Rank	DRG No.	Relative Cost Weight	Discharges	Percent	Average Length of Stay	Average Reimbursement per Discharge
Total				892,137	100.0	7.3	$3,144
1	1	127	1.0300	43,461	4.9	7.4	2,748
2	5	140	0.7470	31,055	3.5	4.9	1,834
3	2	182	0.6121	30,945	3.5	5.3	1,439
4	4	014	1.3386	27,856	3.1	9.3	3,595
5	3	039	0.4958	27,468	3.1	2.0	1,219
6	6	089	1.0914	25,059	2.8	8.0	2,770
7	8	138	0.9200	19,525	2.2	5.4	2,408
8	7	243	0.7473	17,504	2.0	6.9	1,901
9	14	209	2.2674	16,917	1.9	13.6	6,657
10	11	015	0.6604	16,427	1.8	5.0	1,628
11	10	296	0.8886	16,130	1.8	6.7	2,302
12	13	336	0.9974	16,013	1.8	6.9	2,703
13	12	096	0.7913	15,428	1.7	6.4	1,949
14	9	088	1.0304	14,937	1.7	7.2	2,767
15	15	174	0.9185	13,433	1.5	6.4	2,380
16	16	122	1.3509	13,293	1.5	9.1	3,509
17	17	320	0.8039	12,107	1.4	7.1	1,992
18	20	210	2.0617	10,738	1.2	13.9	5,850
19	21	121	1.8454	10,626	1.2	11.1	4,996
20	18	294	0.8003	10,460	1.2	7.1	2,044
21	23	148	2.5228	9,749	1.1	15.1	7,427
22	29	141	0.6408	8,942	1.0	4.7	1,606
23	25	087	1.5368	8,787	1.0	8.2	4,244
24	28	161	0.6995	8,627	1.0	4.5	1,748
25	22	082	1.1282	8,549	1.0	8.2	3,231

(Source: Case Mix monitoring tables using PATBILL records processed in BDMS through January 25, 1985)

Prospective Payment System Monitoring
DRG Analysis--PPS Bills
FY 85 to Date

FY 85 Rank	FY 84 Rank	DRG Number	Description
1	1	127	Heart Failure and Shock
2	5	140	Angina Pectoris
3	2	182	Esophagitis, Gastroenteritis and Miscellaneous Digestive Disorders, Age Over 69 and/or Complicating Conditions
4	4	014	Specific Cerebrovascular Disorders Except Transient Ischemic Attacks
5	3	039	Lens Procedure
6	6	089	Simple Pneumonia and Pleurisy, Age Over 69 and/or Complicating Conditions
7	8	138	Cardiac Arrhythmia and Conduction Disorders, Age Over 69 and/or Complicating Conditions
8	7	243	Medical Back Problems
9	14	209	Major Joint Procedures
10	11	015	Transient Ischemic Attacks
11	10	296	Nutritional and Miscellaneous Metabolic Disorders, Age Over 69 and/or Complicating Conditions
12	13	336	Transurethral Prostatectomy, Age Over 69 and/or Complicating Conditions
13	12	096	Bronchitis and Asthma, Age Over 69 and/or Complicating Conditions
14	9	088	Chronic Obstructive Pulmonary Disease
15	15	174	Gastrointestinal Hemorrhage, Age Over 69 and/or Complicating Conditions
16	16	122	Circulatory Disorders with Acute Myocardial Infarction, without Cardiovascular Complications, Discharged Alive
17	17	320	Kidney and Urinary Tract Infections, Age Over 69 and/or Complicating Conditions
18	20	210	Hip and Femur Procedures Except Major Joint, Age Over 69 and/or Complicating Conditions
19	21	121	Circulatory Disorders with Acute Myocardial Infarction and Cardiovascular Complications, Discharged Alive
20	18	294	Diabetes, Age Over 35
21	23	148	Major Small and Large Bowel Procedures, Age Over 69 and/or Complicating Conditi
22	29	141	Syncope and Collapse, Age Over 69 and/or Complicating Conditions
23	25	087	Pulmonary Edema and Respiratory Failure
24	28	161	Inguinal and Femoral Hernia Procedures, Age Over 69 and/or Complicating Conditi
25	22	082	Respiratory Neoplasms

(Source: Case-Mix monitoring tables using PATBILL records processed in BDMS through January 25, 1985)

Report of PPS Medical Review Activity

Admission Review

	December Data	Cumulative Data 10/1/83 - 12/31/84
Number of PPS Inpatient Hospital Admissions/Discharges	637,976	5,344,956
Total Admissions Reviewed for any Reason (including admission sample)	213,676	1,732,484
Percentage of PPS Inpatient Hospital Admissions Reviewed	33.5%	32.4%
Total Number of PPS Inpatient Hospital Admissions Denied	4,701	40,715
Percentage of PPS Inpatient Admissions Denied of Those Reviewed	2.2%	2.4%

Transfers

	December Data	Cumulative Data 10/1/83 - 12/31/84
Number of Psychiatric Unit Transfers Subjected to Medical Review	322	3,815
Number of Psychiatric Unit Transfers Denied	18	120
Percentage of Cases Denied	6.0%	3.1%
RO Referrals	4	76
Number of Rehabilitation Transfers Subjected to Medical Review	880	9,907
Number of Rehabilitation Transfers Denied	36	563
Percentage of Cases Denied	4.1%	5.7%
RO Referrals	5	34
Number of Alcohol/Drug Transfers Subjected to Medical Review	28	311
Number of Alcohol/Drug Transfers Denied	0	22

	December Data	Cumulative Data 10/1/83 - 12/31/84
Transfers - continued		
Percentage of Cases Denied	0%	7.1%
RO Referrals	0	4
Number of Swing Bed Transfers Subjected to Medical Review	637	3,839
Number of Swing Bed Transfers Denied	32	202
Percentage of Cases Denied	5.0%	5.3%
RO Referrals	0	30
Transfers From a PPS Hospital		
Number of Transfers from a PPS Hospital to any Other Hospital (PPS or Non-PPS) Reviewed	3,677	42,340
Number of Transfers Denied	42	883
Percentage of Cases Denied	1.1%	2.1%
RO Referrals	63	580
Readmissions Within Seven Calendar Days of Discharge from a PPS Hospital		
Number of Readmissions Within 7 Calendar Days of Discharge	17,566	140,646
Number Subjected to Medical Review	9,724	118,265
Number of Readmissions Within 7 Calendar Days of Discharge Denied	266	4,234
Percentage of Readmissions Denied of Those Reviewed	2.7%	3.6%
RO Referrals	218	1,872

	December Data	Cumulative Data 10/1/83 - 12/31/84
Procedure Review		
Number of Cases Involving Pacemaker Insertions Subjected to Medical Review	2,585	26,744
Number of Cases Involving Pacemaker Insertions Denied	39	372
Percentage of Pacemaker Insertions Denied	1.5%	1.4%
Number of Cases Involving Other Procedures Subjected to Medical Review	6,256	28,934
Number of Cases Involving Other Procedures Denied	111	832
Percentage of Cases Denied	1.8%	2.9%
RO Referrals	4	* 37

The number of procedures presently being reported reviewed continues to increase due to PRO review. Each PRO is required by contract to target review on specified elective procedure related DRGs or DRG groups where potential exists for inappropriate utilization or diminishing of quality of care in the area.

* November's data indicated that the Georgia PRO had reported 438 cases referred to the RO in this review category. Contact with the PRO identified that this number (438) was a typographical error and that no procedure review cases were referred to the RO.

Review of Outliers		
Number of Cases Approved in Day Outlier Category	5,330	64,808
Number of Days Approved as Day Outliers	72,910	915,355
Number of Days Denied as Day Outliers	6,986	105,502
Percentage of Day Outlier Days Denied	8.7%	10.3%
Number of Cases Approved as Cost Outliers	2,951	29,822
Amount of Charges Approved as Cost Outliers	$29,240,761	$222,770,355
Amount of Charges Denied as Cost Outliers	$ 1,571,434	* $ 10,448,939
Percentage of Charges for Cost Outliers Denied	5.1%	4.5%

* The cumulative denied cost outlier charges reported during November was incorrect. The amount reported for December has been verified.

	December Data	Cumulative Data 10/1/83 - 12/31/84
DRG Validation		
Total Number of Random Sample Cases Reviewed	41,662	463,625
Number of Cases Reviewed for Other Reasons	78,179	620,431
Total Cases Reviewed (all DRG Validations)	119,841	1,084,056
Number of DRG Errors Identified that Resulted in a Change in DRG Assignment	4,761	N/A

Admission Pattern Monitoring (APM)

NOTE: APM is in the process of being modified. No further activity will be reported until new instructions are issued.

Inpatient Hospital Benefit Payments, Total and PPS, October 1983 to Date

	Total Inpatient Benefit Payments		PPS Benefit Payments			
Month	Monthly	Cumulative	Monthly	Percent of Total	Cumulative	Percent of Total
		(in millions)				
			Fiscal Year 1984			
October	$2,963	$ 2,963	$ 190	6.4%	$ 190	6.4%
November	2,982	5,946	509	17.1	699	11.8
December	3,156	9,102	566	17.9	1,265	13.9
January	3,178	12,280	955	30.1	2,220	18.1
February	3,095	15,375	1,213	39.2	3,433	22.3
March	3,476	18,852	1,415	40.7	4,849	25.7
April	3,304	22,156	1,503	45.5	6,351	28.7
May	3,432	25,588	1,554	45.3	7,905	30.9
June	3,395	28,983	1,672	49.2	9,577	33.0
July	3,231	32,214	1,991	61.6	11,568	35.9
August	3,634	35,848	2,651	72.9	14,218	39.7
September	1,943	37,791	1,565	80.5	15,784	41.8
			Fiscal Year 1985			
October	$4,498	$ 4,498	$3,759	83.6%	$3,759	83.6%
November	3,621	8,119	3,012	83.2	6,771	83.4
December	3,450	11,569	2,829	82.0	9,600	83.0

Source: BPO - PPS Intermediary Benefit Payment Reports through December 1984.
Note: Benefit payments now include current year adjustments to PIP rates and end-of-fiscal-year retroactive adjustments. Excluded are $394 million in inpatient hospital benefits paid by Office of Direct Reimbursement through July 1984 for which monthly detail is not available. Relatively few benefits were paid by ODR under PPS.

Projected and Actual PPS Payments, Fiscal Year 1985 to Date (Amounts in Millions)

Fiscal Year 1985	Projected Expenditures		Actual Expenditures			
	Monthly	Cumulative	Monthly		Cumulative	
	Amount	Amount	Amount	Percent of Projected	Amount	Percent of Projected
October 1984	$3,645	$ 3,645	$3,759	103%	$ 3,759	103%
November	2,750	6,395	3,012	110	6,771	106
December	2,752	9,147	2,829	103	9,600	105

Sources: BPO - PPS Intermediary Benefit Payment Reports through December 1984 and BDMS Actuarial Estimates

Note: Benefit payments now include current year adjustments to PIP rates.

Medicare Short-Stay Hospital Admissions, Fiscal Year 1982 to Date
(through December 1984)

	FY 82	FY 83	FY 84[1/]	FY 85[1/]	Percent Change 82-83	83-84	84-85
		numbers in thousands					
October	921	954	984	962	3.6	3.1	-2.2
November	901	950	946	885	5.4	-0.4	-6.4
December	866	903	891	854	4.3	-1.3	-4.2
Total - First Quarter	2,688	2,807	2,821	2,701	4.4	0.5	-4.3
January	943	1,052	1,046		11.6	-0.6	
February	868	935	959		7.7	2.6	
March	1,015	1,032	1,013		1.7	-1.8	
Total - Second Quarter	2,826	3,019	3,018		6.8	0.0	
April	962	995	1,001		3.4	0.6	
May	964	1,022	1,004		6.0	-1.8	
June	958	976	931		1.9	-4.6	
Total - Third Quarter	2,884	2,993	2,936		3.8	-1.9	
July	931	953	936		2.4	-1.8	
August	959	990	918		3.2	-7.3	
September	932	934	883		0.2	-5.5	
Total - Fourth Quarter	2,822	2,877	2,737		1.9	-4.9	
Fiscal Year	11,220	11,696	11,512	2,701[2/]	4.2	-1.6[3/]	-4.3

[1/] Admissions for February through December 1984 are projected to account for processing lags.

[2/] Year-to-date total.

[3/] About 1.9 percent decrease if adjusted for Leap Year.

Source: Admission notices from Query/Reply System processed in BDMS through January 1985

DATA SOURCES

PPS Biweekly Summary Report - Selected summary data on PPS implementation reported to BPO by the Regional Offices who collect it from Intermediaries. Includes fairly current data for a limited number of items.

Medical Review Reports - Data on PPS admissions, denials, transfers, DRG validation, and outliers reported by Medical Review agents and compiled by HSQB. Includes fairly current data for a number of important PPS impact issues.

Intermediary Benefit Payment Report - Financial report on benefit payments under PPS reported by each Intermediary and compiled by BPO. Expected to be a fairly current and accurate source of benefit payment data.

Admission Notices - Admission counts can be tabulated based on notices of admission submitted each time a Medicare beneficiary enters a hospital. The notices are part of the query/reply system used to determine eligibility, deductible, and benefit status. Admission notices are less accurate than discharge bill records, but are more current. The following table can be used to judge the estimated completion levels for admission notice data:

	Completeness Level for a Month of Admission
End of Month	60-75%
One Month Later	98%
Two Months Later	99%

PATBILL Data - This is the most accurate source of information. It is derived from Medicare bill records as a by-product of administrative processing operations. The processing sequence from hospital to Intermediary to BSS to BDMS includes inherent lags which make the data base less current than workload reports and admission notices. The following table shows historical information on the levels of completeness for PATBILL files at specified periods of time:

Reported to HCFA Central Office	Month of Discharge	Quarter of Discharge	Year of Discharge
End of period	1-3%	42-60%	80-83%
1 month after	35-50%	65-72%	88-90%
2 months after	75-80%	85-90%	94-95%
3 months after	85-90%	91-94%	95-97%

Please note, however, that the flow of PATBILL records appears to have slowed considerably since PPS was implemented on October 1. For example, inpatient hospital bills processed in HCFA during October 1983 - September 1984 (11,446,161) are 10.6 percent lower than bills processed during October 1982 - September 1983 (12,804,108).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

APR 8 1985

The Honorable John Heinz
Chairman
Special Committee on Aging
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

On March 14, 1985, Mr. James L. Scott, Acting Deputy Administrator, Health Care Financing Administration (HCFA), appeared before your Committee to discuss unnecessary surgery for the elderly. At the hearing, you requested written responses to the five questions listed in your March 1st letter of invitation to me. The responses are enclosed.

Please let me know if my office can be of further assistance to your inquiry.

Sincerely,

Lawrence J. DeNardis
Acting Assistant Secretary
for Legislation

Enclosure

1. What is the Department's reaction to the Inspector General's recommendation in favor of a mandatory SSOP in the Medicare and Medicaid programs and to the findings of the HCFA seven-year study of SSOPs?

We agree with the Inspector General's determination that unnecessary surgery existed and that the problem was large enough to warrant action. And we have acted.

We took the findings from the HCFA seven-year study of SSOPs and incorporated them into a program to improve quality of care and reduce unnecessary care. Those findings clearly indicated that the primary success of a mandatory second surgical opinion program resulted from the "sentinel" effect that came from the existence of an oversight mechanism. We have instituted an even stronger, more comprehensive oversight mechanism in the Peer Review Organization (PRO) program now operational in every State.

The PRO program has required review activities that include preadmission review, profile analysis, retrospective review, and focused quality review interventions. We hope this package of oversight activities will provide a direct and sentinel effect that is greater still than that of SSOP. The PRO program will also be able to take advantage of emerging consensus on some surgical procedures where wide and unexplained variations in practice existed across areas with no difference in outcome. This will prevent the need for case by case SSOP which forces beneficiaries to visit more then one doctor. It is also important to note that Medicare payment is available for any second opinion that beneficiaries may seek.

We worked with the Inspector General's Office in the designation of the specific procedures to be considered for targeted analysis by the PROs. Most of the 8 procedures identified by the IG to be significant for Medicare have been incorporated and are among the review activities of most PROs.

2. In light of the findings of the HCFA study of SSOPs and the recommendation of the Inspector General, is the Department prepared at this time to commit to serious and expeditious consideration of a mandatory SSOP in the Medicare and Medicaid programs?

The HCFA study of SSOPs found positive results in the Massachusetts Medicaid mandatory SSOP. As the study pointed out, there is no evidence that a mandatory SSOP would have similar results for Medicare. The populations differ and the procedures differ.

The Massachusetts Medicaid SSOP targeted procedures performed overwhelmingly on women of childbearing age and children under age 18. Less than 1 percent of program participants were over-65 while 44 percent of procedures reviewed were tonsillectomies and 22 percent were hysterectomies.

As pointed out in response to question 1, we believe that the PRO program will provide the necessary means to reduce unnecessary surgery for Medicare.

For Medicaid, we believe that the States should have the opportunity to select their own mechanisms to attack this problem. Nearly half the States have contracted with PROs to address this problem; 7-12 States have mandatory SSOP; and 21 States have prior authorization requirements that are even more restrictive than mandatory SSOPs.

3. Does the Department see a need to amend the Social Security Act for implementation of a mandatory SSOP in the Medicare and/or Medicaid programs, and, if so, in what respect(s)?

To implement a mandatory SSOP program for Medicare, Congress would need to amend Section 1862(a) of the Social Security Act to exclude from coverage certain surgical procedures unless the beneficiary has participated in the mandatory second surgical opinion program. Other areas of the law might require modification as well, depending upon operational decisions.

To implement a mandatory SSOP program for Medicaid, Congress would need to amend Section 1903(b) of the Social Security Act to exclude Federal Financial Participation (FFP) for certain surgical procedures unless the recipient participates in a mandatory SSOP.

4. Federal law permitting, could a mandatory SSOP be added to the existing utilization review performed by the PROs?

There is no need to burden beneficiaries with requirements to visit more than one physician. The PROs have implemented multiple mechanisms to deal with unnecessary surgery including pre-admission review for selected diagnosis.

We need to allow the PROs to reach full operational capacity and evaluate their effectiveness before we burden them with untested and duplicative requirements at such an early stage in their operation.

5. If mandated by the Congress, what is the Department's preference for implementing a mandatory SSOP in the Medicare and Medicaid programs? Should it be implemented simultaneously in all States? Should it be phased in gradually in all of the States? Or should there be a demonstration project for a set period with concurrent research study and monitoring to measure results?

We have no experience with mandatory SSOP for Medicare. As mentioned earlier, the Medicare population is not like other populations and findings from other studies are not transferable to this entitlement program. Furthermore, we know that the impact of SSOPs rests on the "sentinel effect" and the Medicare population is benefiting from that effect already through the PRO program. We would need to assess on a limited basis the incremental value of a mandatory Medicare SSOP for those procedures in which PROs are not already doing pre-admission review before applying such a requirement to the current environment nationally.

In summary, we believe the best approach is to assess the effects of PRO activities before making further recommendations. We are fully committed to monitoring PRO activities, including pre-admission review.

Department of Health and Human Services
Richard P. Kusserow
Inspector General

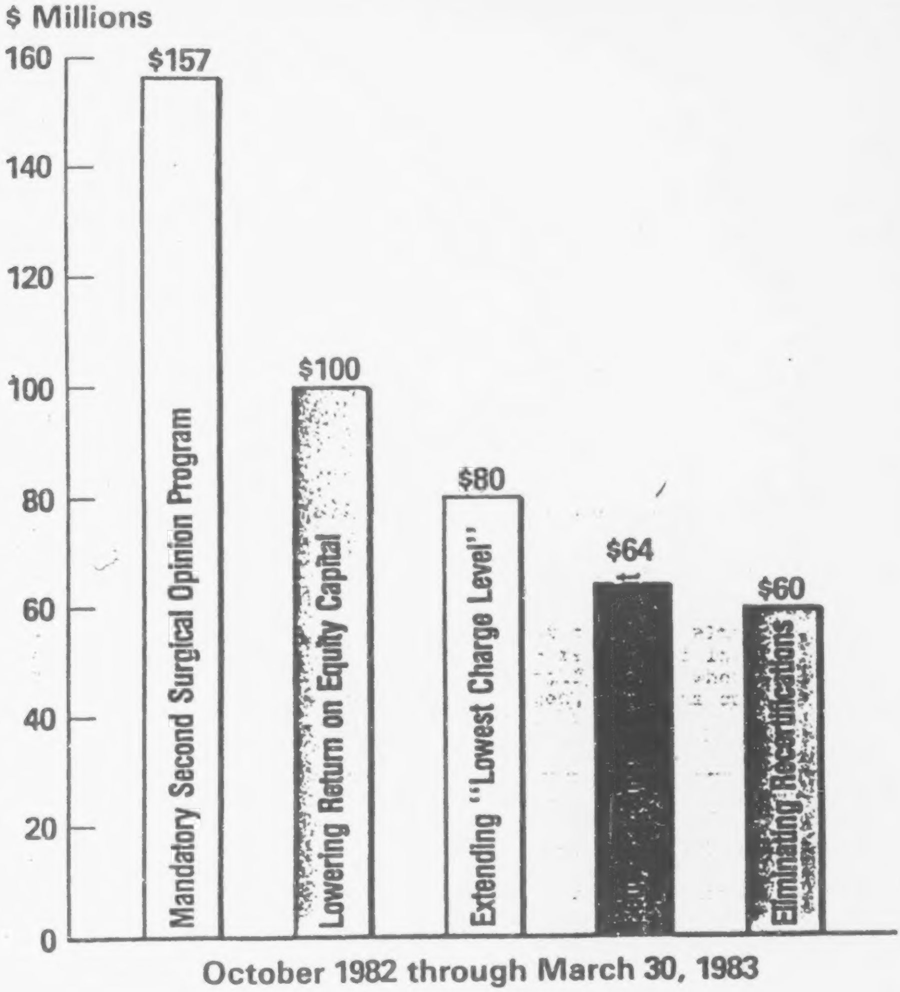
OFFICE OF INSPECTOR GENERAL

Semiannual Report

October 1, 1982 - March 31, 1983

—$461 MILLION—

COST SAVINGS IF INSPECTOR GENERAL HEALTH RECOMMENDATIONS ARE IMPLEMENTED



MEDICARE-MEDICAID LEGISLATIVE/REGULATORY REFORM

Auditors identified five areas where $461 million could be saved if regulatory or legislative changes were made in specific program areas. Highlights of these items follow:

MANDATORY SECOND SURGICAL OPINION PROGRAM CAN SAVE $157 MILLION

A 1976 House Subcommittee on Interstate and Foreign Commerce Report estimated 2.4 million unnecessary surgeries were performed in one year at a waste of 11,900 lives and $4 billion. The report recommended that HCFA promptly implement a program of independent second opinions for elective surgeries paid under Medicare and Medicaid.

Auditors assessed the adequacy of actions taken by HCFA to cut down on this problem and to implement the Congressional mandate. Despite a promising start in sponsoring a voluntary second opinion program during 1977, experience over the last 5 years has shown that neither Medicare nor Medicaid beneficiaries seek second opinions as a general rule.

Studies on second surgical opinion programs consistently point out that voluntary programs have a limited impact; however, the opposite holds true for mandatory programs. For example, based on our study, mandatory programs covering even a limited number of the more common procedures could reduce elective surgeries nationwide by as much as 29 percent in Medicaid and 18 percent in Medicare at an annual cost savings of about $63 million and $94.7 million, respectively. The Office of Inspector General (OIG) recommends that HCFA seek a legislative change to the Social Security Act that would require Medicare and Medicaid beneficiaries to seek a mandatory second surgical opinion for selected types of elective surgery.

Although HCFA agrees that mandatory second surgical opinions appear cost-effective, experience with these programs has been limited. Therefore, they feel it would be premature to seek legislation without further study.

* * * * * *

OFFICE OF
INSPECTOR GENERAL

Semiannnual Report

October 1, 1983 - March 31, 1984

Department of Health & Human Services - USA

RICHARD P. KUSSEROW
INSPECTOR GENERAL

DURABLE MEDICAL EQUIPMENT

Current Medicare rules provide that it is the beneficiary's decision to purchase or rent durable medical equipment. We developed a computer application designed to compare the aggregate of rental costs for each durable medical equipment (DME) item to the purchase price of that item. The results of this application indicated a Medicare savings of $1.7 million from purchase rather than rental of DME items.

If the same conditions exist nationwide, cost savings could be $50 to $100 million annually. Our review is continuing.

DUPLICATE PHYSICIAN/ LABORATORY CLAIMS

Carrier prepayment screens are normally designed to detect "exact" duplicates, that is, the same provider, same beneficiary, and same date of service. There are few screens to detect duplicate services rendered to a beneficiary on the same day (or for a range of days) by two or more different providers.

We designed a computer application to match one carrier's physician and laboratory claims files to identify two different providers (a physician and a laboratory) that billed for the same service on the same day or from one to three days apart on behalf of a beneficiary.

We identified over 5,100 potential matches where a maximum of $32,641 was overpaid for services rendered within one to three days apart. Additionally, one provider is being investigated. Our review is continuing.

IG Recommendations Not Yet Acted Upon

In the following areas, OIG recommendations included in previous reports to Congress involving significant dollar savings have still not been implemented.

SECOND SURGICAL OPINIONS

Studies on second surgical opinion programs (SSOPs) consistently point out that mandatory programs are effective in reducing unnecessary surgery. For example, one study showed mandatory programs covering just the more common procedures could reduce elective surgeries nationwide by as much as 29 percent in Medicaid and 18 percent in Medicare at annual cost savings of about $65 million and $135 million, respectively, using 1984 dollars.

We recommended that HCFA seek a legislative change to the Social Security Act that would require Medicare and Medicaid beneficiaries to seek a mandatory second surgical opinion for selected surgeries.

HCFA agreed that there is evidence that a mandatory SSOP might reduce the amount of unnecessary surgery performed. HCFA believed, however, there were many unanswered questions in this area and contracted for an evaluation of the overall effects of a mandatory SSOP and the long-term savings from such a program.

MEDICARE ROUND DOWN

Based on a study at two carriers, we estimated Medicare Part B could save about $45 million annually or $225 million over a 5-year period if payments for odd-penny claims were rounded, on a per claim basis, to the next lower whole dollar.

The effect of such a policy on the individual beneficiaries or physicians/suppliers would be minimal—about 30 cents per paid claim. We proposed that HCFA seek authority to institute such a practice.

Legislation to implement this recommendation is under consideration in the Department and the Congress.

HOUSEKEEPING SERVICES

One State charged housekeeping services (e.g., shopping, ironing) for recipients to the Medicaid program without requiring that they be medically necessary by being linked to a "physician's plan of treatment." We found that this one State alone claimed $15 million over a 15-month period for such services. We estimate that, nationwide, improper claims could run as high as $30 million annually.

Although HCFA agreed to review the involved regulation, they have not, to date, taken action to correct this problem.

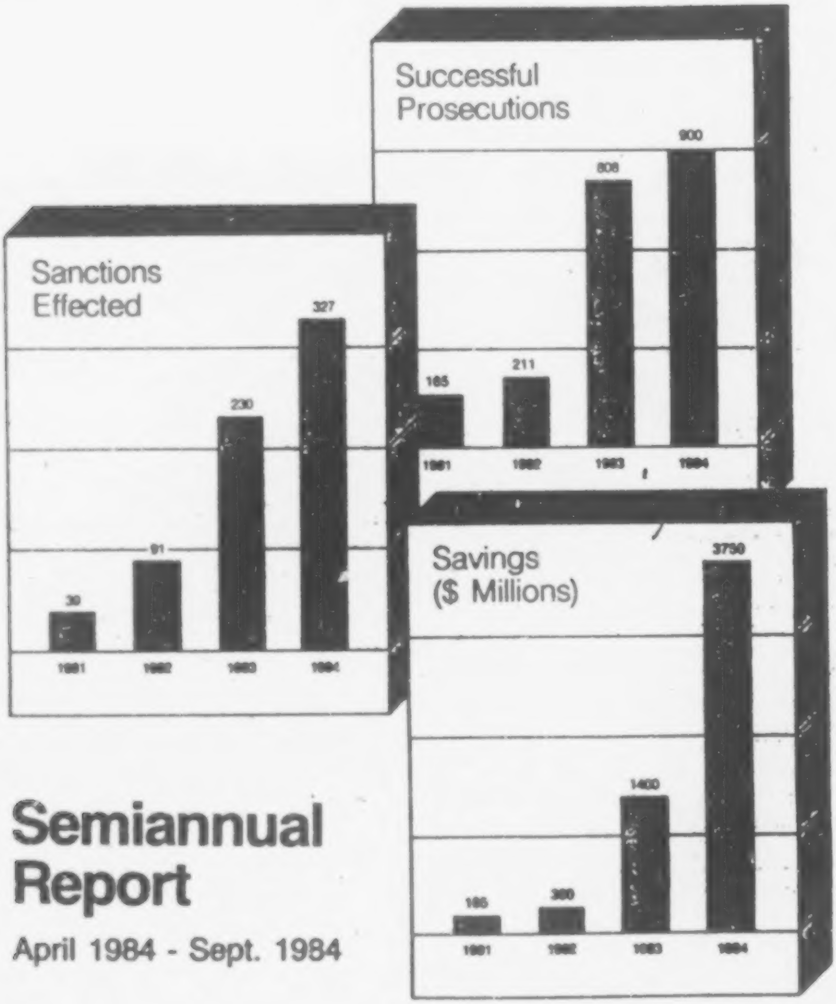
PSYCHIATRIC SERVICES

At a number of health facilities, we found psychiatric services were not limited to traditional treatment, but included a broad spectrum of services usually provided at an off-site location. Many of these services seemed of a social, recreational, or educational nature and thus suspect for reimbursement under Medicaid. The lack of clarity as to what constitutes "medically justifiable" services, coupled with the failure to define "billable encounters," in our opinion, results in significant abuses. At $54 authorized per patient visit, some $10 to $20 million annually could be involved nationwide.

Though HCFA initially agreed with us that Medicaid standards for outpatient psychiatric services were needed, they have not taken the necessary implementing action.

Department of Health and Human Services
Richard P. Kusserow
Inspector General

OFFICE OF INSPECTOR GENERAL



Semiannual Report

April 1984 - Sept. 1984

- A chiropractor was suspended for 10 years for fraud. He had demonstrated a disregard for the welfare of his patients.

- A medical center administrator was removed from participation for 15 years as a result of forgery of physicians' signatures.

- The director of a day care center was barred for 5 years for filing false statements while participating in the Title XX (social services) program.

An example of an action taken on the basis of a recommendation from a Professional Standards Review Organization (PSRO) that a practitioner or health care provider has failed to provide quality care or care which is medically necessary follows:

- A physician who provided poor quality of care, such as not documenting patient's cardiac conditions and neurological status, was excluded for 5 years.

Recommendations Not Yet Acted Upon

The following OIG recommendations included in previous reports to Congress and involving significant dollar savings have still not been implemented:

SECOND SURGICAL OPINIONS

Studies on Second Surgical Opinion Programs (SSOPs) consistently point out that mandatory programs are effective in reducing unnecessary surgery. For example, one study showed mandatory programs covering just the more common procedures could reduce elective surgeries nationwide by as much as 29 percent in Medicaid and 18 percent in Medicare at annual cost savings of about $65 million and $135 million, respectively, using 1984 dollars.

We had recommended that HCFA seek a legislative change to the Social Security Act that would require Medicare and Medicaid beneficiaries to seek a mandatory second surgical opinion for selected surgeries.

HCFA agreed that there is evidence that a mandatory SSOP might reduce the amount of unnecessary surgery performed. HCFA believed, however, there were many unanswered questions in this area and contracted for an evaluation of the overall effects of a mandatory SSOP and the long-term savings from such a program. HCFA expects to have the results of this study by late 1984. (Report first discussed in OIG Semiannual Report, October 1982 - March 1983.)

PSYCHIATRIC SERVICES

At a number of health facilities that we reviewed, psychiatric services were not limited to traditional treatment, but included a broad spectrum of services usually provided at an off-site location.

Many of these services seem of a social, recreational, or educational nature and thus, suspect for reimbursement under Medicaid. The lack of clarity as to what constitutes "medically justifiable" services, coupled with the failure to define "billable encounters," in our opinion, results in significant abuses. At $54 authorized per patient visit, some $10 or $20 million annually could be involved nationwide.

HCFA recently started acting on our recommendation to see that Medicaid standards for outpatient psychiatric services are put into place. Questionnaires have been circulated to the States to determine the extent of this problem which will be a main topic of discussion at the next State Medical Group meeting. (Report first discussed in OIG 1980 Annual Report.)

HOUSEKEEPING SERVICES

One State charged the cost of housekeeping services such as shopping and ironing for recipients to the Medicaid program without requiring that they be medically necessary by being linked to a "physician's plan of treatment." We found that this one State alone claimed $15 million over a 15-month period for such services. On a nationwide basis, we estimate that improper claims of this type could run as high as $30 million annually.

Although HCFA agreed to revise the involved regulation to correct this problem, such revision has not been made. (Report first discussed in OIG 1980 Annual Report.)

MEDICARE ROUND DOWN

Based on a study at two carriers, we estimated Medicare Part B could save about $45 million annually or $225 million over a 5-year period if payments for odd-penny claims were rounded, on a per claim basis, to the next lower whole dollar.

The effect of such a policy on the individual beneficiaries or physicians/suppliers would be minimal—about 30 cents per paid claim. We proposed that HCFA seek authority to institute such a practice. (Report first discussed in OIG Semiannual Report, April 1983 - September 1983.)

DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

[illegible] - 5

The Honorable John Heinz
Chairman, Special Committee on Aging
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

In accordance with your request conveyed through a Committee staff member, I am happy to provide you with additional comments on specific issues relative to the effectiveness of mandatory second surgical opinion programs and Professional Review Organizations in reducing unnecessary surgeries funded by Medicare.

I understand that you are considering introducing legislation requiring mandatory second opinion programs for Medicare and Medicaid. This being the case, I believe this is an opportune time to present you with a capsulized report detailing the Office of Inspector General's position on the issue of mandatory second opinion programs, particularly for Medicare beneficiaries.

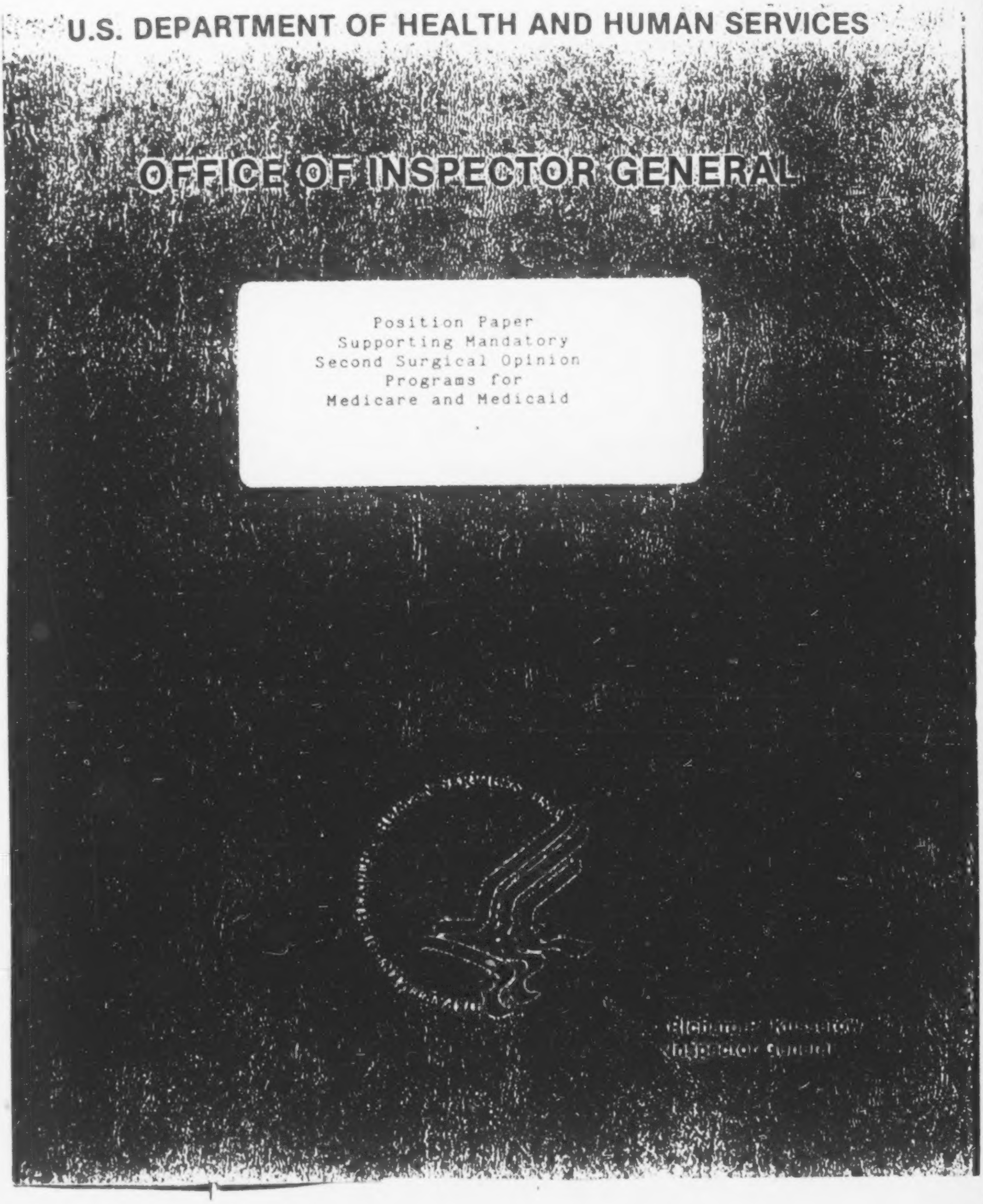
You will note from the enclosed position paper that I fully support your efforts to bring about a mandatory second opinion program as a means to protect the nation's elderly and poor from being victimized by unnecessary and oftentimes dangerous surgery. I remain firmly convinced that mandatory programs are needed; that such programs will be effective for Medicare beneficiaries and Medicaid recipients; and that Professional Review Organizations do not eliminate the need for mandatory second opinion programs in Medicare.

Sincerely yours,

RP Kusserow

Richard P. Kusserow
Inspector General

Enclosure



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

Position Paper
Supporting Mandatory
Second Surgical Opinion
Programs for
Medicare and Medicaid

Richard P. Kusserow
Inspector General

Office of Inspector General
Executive Summary

The Department of Health and Human Services and Congress have long been concerned over unnecessary surgeries. Throughout the years the Department has established national voluntary second surgical opinion programs (SSOPs); has actively encouraged all citizens to obtain a second opinion prior to elective surgery; and has spent considerable funds financing two Medicare demonstration projects. Additional funds were spent studying several voluntary and mandatory SSOPs.

In March 1983, the Office of Inspector General (OIG) issued a report to the Administrator, Health Care Financing Administration (HCFA) pointing out that voluntary SSOPs were ineffective in reducing unnecessary surgeries. Mandatory programs, on the other hand, were recognized to be very effective. The Inspector General recommended that mandatory SSOPs be adopted for Medicare beneficiaries and Medicaid recipients. HCFA disagreed citing a need for additional study.

Recent hearings conducted by the U.S. Senate Special Committee on Aging made it clear that unnecessary surgeries remain a serious problem, particularly in Medicare. HCFA's current strategy, which was enunciated at the hearings, is to combat this problem through a sentinel effect -- a phenomenon whereby physicians initially recommend fewer surgeries because they know their decisions to operate will be reviewed by other physicians -- generated by reviews conducted by Professional Review Organizations (PROs). HCFA believes that because its sponsored studies have shown the sentinel effect to be the major cause of surgery reductions attributed to mandatory SSOPs, PRO reviews of hospital admissions will generate a similar sentinel effect and will, therefore, enjoy similar success in reducing unnecessary surgeries. Mandatory SSOPs are not favored by HCFA.

The OIG strongly supports the PRO concept and recognizes that PROs are an integral part of the network of controls aimed at preventing Medicare abuses. The OIG does not agree, however, that PROs eliminate the need for mandatory SSOPs for Medicare beneficiaries.

Unlike second opinion programs where patients are examined by other physicians, PROs are not required to contact patients or arrange additional examinations for them. Therefore, PROs are not able to alert patients to the risks associated with surgery which, according to the Abt Associates, Inc. study, are a major cause of the high nonconfirmation rates (i.e., cases in which the consulting physician does not agree that surgery is necessary) experienced by the elderly. PROs are also unable to inform patients of alternate methods of treatment which may be more appropriate than surgery. Considering that physicians could not agree on the need for surgery for about 30 percent of all Medicare beneficiaries participating in the HCFA sponsored New York demonstration project, these are indeed serious shortcomings.

The sentinel effect associated with PRO reviews will, if it is as large as anticipated by HCFA, reduce the nonconfirmation rate. The OIG has serious doubts, however, that the sentinel effect generated by the PROs will be of equal import as the sentinel effect generated by mandatory SSOPs. Reviews of documentation in medical records are quite different than examinations of patients where all diagnoses are verifiable. This difference is easily recognizable by physicians and may lessen the effectiveness of this approach. Furthermore, PROs provide less than 100 percent review of surgical procedures provided to hospital inpatients and no coverage of surgery performed outside hospital settings. Consequently, this will limit their effectiveness in reducing unnecessary outpatient surgery and also reduce the sentinel effect.

The OIG, after considering all available evidence on this issue, believes that mandatory SSOPs are still needed to reduce unnecessary surgeries. Therefore, this office supports legislation to require mandatory SSOPs for Medicare and Medicaid.

VOLUNTARY SECOND SURGICAL OPINION PROGRAMS -- HHS RESPONSE TO CONGRESSIONAL CONCERNS OVER UNNECESSARY SURGERY

The Congress has long been concerned that unnecessary surgery is wasting American lives and dollars. In January 1976, the Subcommittee on Oversight and Investigations of the House Committee on Interstate and Foreign Commerce reported that an estimated 2.4 million unnecessary surgeries were performed in 1974 at a cost of 11,900 lives and $4 billion.1/ The House report concluded that second consultations could cut down significantly on unnecessary surgery. It recommended that our Department:

1. Promptly institute a program of independent second professional opinions to confirm an individual's need for elective surgery if it was to be funded by Medicare or Medicaid.

2. Carefully evaluate that program to determine (a) its impact on quality of care; (b) its ability to contain health care costs; (c) the percentage of surgeries being performed that are unnecessary; and (d) the cost of administering such a program compared with the cost of paying for unnecessary surgery.

In response to the Committee report, the Health Care Financing Administration (HCFA) launched a national second opinion program in 1977. It arranged for a great deal of publicity for the program and established a national hotline. Referral centers were opened to encourage people to voluntarily seek a second medical opinion before undergoing elective surgery and to help them locate physicians willing to provide that opinion. The main objectives of the national program - which was aimed at the general population - were to (1) decrease the amount of inappropriate surgery performed thereby avoiding the costs and risks of surgery without jeopardizing the health and well-being of patients and (2) influence patients' behavior by encouraging them to be more informed and involved in decisions on their health care.

As part of its overall effort, HCFA not only agreed to pay Medicare's normal share of physician charges for second opinions, but also initiated, in 1978, two demonstration projects - one in New York and one in Michigan. Their purpose was to test the concept of second opinions on Medicare beneficiaries in particular and to determine whether the financial incentive of waiving Medicare copayment and deductible amounts would induce beneficiaries to voluntarily seek second opinions.

1/ U.S. Congress, House of Representatives. Cost and Quality of Health Care: Unnecessary Surgery. 94th Congress, 1976

HCFA also encouraged States to pay for second opinions under Medicaid. As a result, State Medicaid agencies agreed to include second opinions as a covered service. Seven States went further. At the time of our review, Massachusetts, Michigan, Wisconsin, New Jersey, Washington, Connecticut and Missouri had mandatory second surgical opinion programs (SSOPs) in operation. Under these programs, recipients were required to obtain second opinions for selected surgical procedures as a condition of Medicaid coverage. The procedures were chosen on the basis of volume, cost, and expected rate(s) of nonconfirmation (i.e., cases in which the consulting physician does not agree that surgery is necessary).

Under each of these mandatory programs, the decision to have or not have the elective surgery rested with the Medicaid recipient. A dissenting second opinion had no effect on coverage if the recipient chose to have the surgery performed.

OIG REVIEW OF SECOND SURGICAL OPINION PROGRAMS

In late 1982, the Office of Inspector General (OIG) began a review of SSOPs to see what effect they were having on the numbers of elective surgeries in Medicare and Medicaid. We wanted to know whether or not such programs worked and if so, what type worked best. Based on our analysis of data available at that time, we concluded that Medicare's voluntary SSOPs were not having the desired effect, but that Medicaid's mandatory programs were reducing the number of elective surgeries.

Voluntary Programs Were Not Effective

The basic reason why voluntary SSOPs were not effective was simply that people did not voluntarily seek a second opinion prior to elective surgery. Nowhere is this fact more evident than in the two Medicare demonstration projects funded by HHS.

For example, under the New York project, only 1,763 beneficiaries (or 1.2 percent of the 142,000 who received surgery in that year) voluntarily sought second opinions. The rate was even lower -- 0.3 percent — in the Michigan project where only 116 second opinions were obtained for about 44,000 surgeries. These extremely low use rates become even more discouraging when it is considered that under both projects, second opinions were available at no cost to beneficiaries.

The low rates, which incidentally were about norm for all voluntary SSOPs, cannot be attributed to anything that HCFA did or did not do as it made every effort to encourage beneficiary participation. Chrysler Corporation, in a study of its own program, was likely correct when it concluded that voluntary programs do not work because people do not want to offend their physicians by requesting second opinions.

Results of the two demonstration projects lend credence to this theory. About 80 percent of the projects' participants requested that the referral center not contact the first opinion physician. This certainly indicates that although beneficiaries did not fully agree with their physician's decision to operate, they still wanted to avoid the appearance of confrontation, mistrust, and so on.

There is general agreement within HHS that voluntary SSOPs are not effective. HHS reported to the Congress in March 1982 2/ that waiving cost-sharing as an incentive for Medicare beneficiaries to voluntarily obtain second opinions did not appear to result in extensive use of second opinions. It further concluded that "the most striking fact regarding all voluntary SSOPs is that few people choose to use them."

It is important to note here that HHS was not restricting this conclusion to only the two Medicare demonstration projects. The evidence is clear for all voluntary programs -- less than five percent of potential recipients take advantage of them.

Mandatory Programs Effective in Reducing Surgeries and Costs

As mentioned earlier, seven States had implemented mandatory SSOPs at the time of our review. Three of these States shown below had sufficient experience with the programs to be able to reach conclusions about their value in reducing elective surgery.

MICHIGAN

The Michigan program started on January 1, 1980. A preliminary study made by the Michigan Department of Social Services found that surgical utilization dropped about 35 percent for seven procedures included in the mandatory program. Annual savings attributable to the program was estimated at $3.7 million.

WISCONSIN

The Wisconsin Department of Health and Social Services, in a report to its State legislature, estimated that overall surgery dropped by 33 percent as a result of its mandatory program. The program covered ten procedures. The State Agency concluded that $22 was saved for every $1 spent on the program, for an annual savings of $2.8 million.

2/ Department of Health and Human Services. Report on Medicare Second Surgical Opinion Programs: The Effect of Waiving Cost-Sharing. March 25, 1982.

MASSACHUSETTS

The Massachusetts mandatory SSOP was required by the State legislature in 1977. The program underwent two reviews by independent researchers. The first study was published in January 1982 by a group of several researchers.3/ The study concluded that the program caused a 20 percent reduction in the volume of those surgical procedures covered by the program and that it saved Medicaid $3 to $4 for every dollar spent to administer it.

The second independent study was performed under a HCFA contract by two researchers employed by Abt Associates, Inc., Cambridge, Massachusetts.4/ In a preliminary report dated November 1982, the researchers concluded that the mandatory program:

"Results in statistically significant decreases in the surgery rate for the eight program procedures taken together -- the decrease ranging between about 15 and 30 percent across five geographic areas. The net savings due to the program is estimated to be about $1 million annually."

The researchers also commented that while it was not yet known how mandatory programs effect patients' health, it was reasonable to hypothesize that additional information provided by a second opinion would, on average, enable patients to make better decisions about undergoing surgery and thereby result in improved health outcomes.

There were other studies as well that demonstrated the effectiveness of mandatory SSOPs. One such study5/ made by Dr. Eugene G. McCarthy under a HCFA contract described 8 years of experience with the Cornell, New York Hospital second opinion program. Dr. McCarthy wrote that 18.7 percent of the participants in the mandatory program were advised not to undergo surgery by consultants and that, after one year, 61.4 percent of them had no surgery performed. Most of these patients stated their decision not to have surgery was based upon the advice of the second physician.

3/ Martin, Shwartz, et al. Impact of a Mandatory Second Opinion Program on Medicaid Surgery Rates. January, 1982.

4/ Poggio and Goldberg. The Mandatory Second Surgical Opinion Program for Medicaid in Massachusetts: A Cost Effectiveness Analysis. November 1982.

5/ Health Care Financing Administration Office of Research, Demonstration and Statistics. Eight Years' Experience With A Second Opinion Elective Surgery Program: Utilization and Economic Analysis. March 1981.

Interestingly, over one-half of these patients reported they received no medical treatment after the consultation. The researchers questioned why surgery had been recommended in the first place and classified this as potential surplus surgery. The report concluded that "the demonstrated cost savings potential of a mandatory second opinion program justified the inclusion of such a program in the array of cost containment initiatives already adopted or under consideration as means of controlling the rise in medical care costs".

It is clear from these studies that reduction in the rate of elective surgery is much greater in mandatory SSOPs than in Medicare's voluntary programs. A major reason for this difference is that mandatory programs are enhanced by what is known as the sentinel effect. This is a phenomenon whereby physicians initially recommend fewer surgeries because they know that their decisions to operate will be reviewed by other physicians. Since most patients do not customarily seek second opinions on their own volition, the sentinel effect has little impact on voluntary programs.

We believe that HCFA correctly summed up the results of available studies on second opinion programs when, in the Department's March 1982 report to Congress, it concluded that sponsored studies have shown mandatory programs to be cost effective in both the public and private sector.

OIG Recommends Mandatory Programs

We are convinced that mandatory SSOPs are good for the patients and the Medicare and Medicaid programs. Patients benefitted as they were provided with sufficient information to make intelligent decisions about elective surgery and that based on this information a sizeable percentage of patients avoided surgery. To the extent that some patients decided against unnecessary or marginally necessary surgery because of the second opinion, they avoided the risk of anxiety or pain resulting from surgery, and possibly exposure to the danger to life itself often posed by surgery and related anesthesia. This is particularly true for Medicare patients who face much higher risks of complications, disability and death as they grow older.

The Medicaid and Medicare programs would also benefit in that avoided surgeries saved program dollars. Available data showed that mandatory Medicaid SSOPs were feasible and could result in significant savings. We estimated $60 million per year could be saved if all the States were required to implement mandatory programs for just nine elective procedures. Similar data were not available for Medicare, but extrapolating from the HHS report to the Congress and other data, we estimated that such a program for Medicare could save about $95 million per year - depending on the surgical procedures included.

We, therefore, recommended in March 1983 that HCFA take the steps necessary to put mandatory SSOPs into effect in the Medicare and Medicaid programs. HCFA disagreed, citing a need for further analysis and study.

OIG CONCLUSION -- MANDATORY SSOPs ARE STILL NEEDED

In March 1985, the Senate Special Committee on Aging, chaired by Senator John Heinz, released a report in conjunction with hearings held on the need for mandatory SSOPs in Medicare and Medicaid. The Committee report found that a reduction in nine common non-emergency surgeries could save up to $1.2 billion annually in Medicare payments.

The Inspector General was called before the Committee to discuss his views on the potential for second opinion programs to reduce the number of elective surgeries funded by Medicare and Medicaid. He testified that such programs can be truly effective but only if they require a second medical opinion as a precondition for coverage of certain surgical procedures. His testimony was supported by several other witnesses including elderly citizens who avoided operations because of second opinions; representatives of businesses that include mandatory SSOPs in employee health plans; physicians experienced with second opinion programs and an official of the American Association of Retired Persons. These witnesses urged the Committee to introduce legislation calling for mandatory SSOPs for Medicare and Medicaid.

A HCFA representative also appeared as a witness. He testified that HCFA believes that quality of care can be improved and program savings achieved by preventing unnecessary surgery. The official informed the Committee that this can best be accomplished through pre-admission screening by Peer Review Organizations (PROs) and State Medicaid agencies, rather than by mandatory SSOPs. Given efforts already in place to reduce unnecessary surgery in the Medicare and Medicaid programs, HCFA does not support requiring national mandatory SSOPs.

Since the hearings, other concerns were raised about the need for mandatory SSOPs, particularly for Medicare beneficiaries. One concern was that the sentinel effect generated by Medicaid mandatory SSOPs would not be generated by Medicare mandatory SSOPs; therefore, the latter program would not be as effective. Another concern was that PROs do, in fact, eliminate the need for mandatory SSOPs in Medicare. A third concern was that the Medicaid studies cited in the OIG report to HCFA were really not very useful in measuring the effectiveness of SSOPs.

We would like to address these three concerns because, in our opinion, they are not valid. The OIG's position is that mandatory SSOPs would be effective in Medicare and are still needed to reduce unnecessary surgeries.

Mandatory SSOPs For Medicare Beneficiaries Can Duplicate Medicaid's Success

Before giving our reasons as to why we believe Medicare SSOPs can be as successful as Medicaid's, we would like to reestablish the fact that Medicaid's SSOPs are successful. It is true that two of the studies cited in our audit report (Michigan and Wisconsin) were not as scientifically sophisticated as the Abt Associates, Inc., study of the mandatory SSOP in Massachusetts. Nevertheless, the studies do provide meaningful data and clearly show that the programs are very similar to Massachusetts in that they too reduce elective surgeries and save money.

More recent studies show the same thing. New Jersey,6/ for example, in evaluating its mandatory SSOP, reported significant surgery reductions for all six of the second opinion procedures. Hysterectomies dropped 44.7 percent, cholecystectomies dropped 31 percent and tonsillectomies/adenoidectomies dropped 40.1 percent to cite a few examples. New Jersey recognized that the reduction may have been the result of other factors, and therefore, evaluated control procedures chosen because they were included in SSOPs implemented by other states. Although a decreased utilization rate was noted for some of the control procedures, the decreases were neither as dramatic or as consistent as those noted for the second opinion procedures. Tennessee is another state that attributed significant Medicaid cost savings (over $1 million) solely to a mandatory SSOP. These states, similar to the states previously discussed, attributed most of the savings to the sentinel effect.

We believe that mandatory SSOPs would also reduce the number of elective surgeries in Medicare because the sentinel effect, which has been credited with most of Medicaid's success in reducing surgery, applies equally as well to Medicare.

As mentioned previously, the sentinel effect is a behavior modification phenomenon whereby physicians initially recommend fewer surgeries because they know that their decisions to operate will be reviewed by and perhaps challenged by other physicians. The impact of the sentinel effect in reducing unnecessary surgeries, therefore, depends on the number of surgery decisions that will be reviewed and the number that could be potentially challenged by the second opinion physicians.

The sentinel effect does not depend on the type of patient involved, i.e., Medicaid recipient versus Medicare beneficiary. This is borne out in numerous studies which have concluded that voluntary SSOPs, regardless of their patient clientele, do not generate a sentinel effect. Physicians know that few patients voluntarily obtain second opinions and thus have little fear of peer review and challenge. On the other hand, studies universally claim a significant sentinel effect for mandatory programs. Moreover, HCFA in its testimony before the Special Committee on Aging concluded that a sentinel effect can be applicable to surgeries funded by Medicare.

Because of the sentinel effect, State Medicaid Agencies that operate mandatory SSOPs generally select surgical procedures for second opinions that are high in volume and have high rates of nonconfirmations. Inclusion of surgical procedures meeting this criteria results in significant reductions in the targeted surgery.

6/ Department of Health Services. Evaluation of Medicaid Second Opinion Program. September 1983.

For example, the Abt Associates, Inc. draft report[7] on the effectiveness of the Massachusetts mandatory SSOP for Medicaid attributed 92 percent of the surgery reductions (state-wide surgery reduction totalled 23.8 percent) to the sentinel effect. The Wisconsin State Medicaid Agency reached a similar conclusion in a report to the State legislature. In the report, the State Agency claimed that of the 33 percent overall reduction in surgery attributed to the mandatory SSOP, about 90 percent was caused by the sentinel effect.

In our report to HCFA, we proposed a mandatory SSOP for Medicare which included nine surgical procedures that met the criteria for a significant sentinel effect -- high in volume and high nonconfirmation rates. The nine procedures also had a proven track record under Medicaid as state programs experienced sharp drops in surgery rates for these procedures.

The following chart contains the latest statistics from the National Center for Health Statistics for several of the procedures included in our proposed mandatory SSOP. It shows not only the significant number of operations performed on the elderly but also the fact that it is the elderly who are far more likely to undergo these operations.

	# of Operations on Patients		Rate for 100,000 People	
Surgery	Under 65	Over 65	Under 65	Over 65
Prostate	83,000	274,000	40.5	990.1
Joint Replacement	106,000	41,000	51.7	149.0
Hernia	370,000	140,000	180.6	510.5
Cataract	129,000	501,000	63.0	1,828.0
Cholecystectomy	331,000	156,000	161.5	570.1
Hysterectomy	619,000	53,000	302.1	192.7
Hemorrhoidectomy	113,000	21,000	55.1	75.6

These procedures obviously meet the criteria for volume. As illustrated below, we believe there is also sufficient evidence to show that the above surgical procedures meet the remaining criteria for a sentinel effect - the fear felt by physicians that their surgery decisions will be challenged.

	Nonconfirmation Rates			
Surgery	New York Demonstration Project - Voluntary	Cornell Voluntary	Cornell Mandatory	Wisconsin Mandatory
Prostate	37.6	41.0	28.9	0
Joint Replacement	25.4	N/A	N/A	3.5
Hernia	14.6	14.6	5.8	5.8
Cataract	33.1	30.1	15.2	3.5
Cholecystectmy	24.8	11.6	8.1	5.4
Hysterectomy	32.6	41.3	30.7	11.9
Hemorrhoidectomy	26.5	N/A	N/A	13.9

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[7] Abt Associates Inc. Second Surgical Opinion Program: Public Policy Alternatives. December 1984.

This information indicates several things. It shows that the elderly enrolled in voluntary programs receive nonconfirmations at a higher rate than the general population. It also shows that nonconfirmation rates for voluntary programs are higher than they are in mandatory programs, a possible indication of the sentinel effect at work. Finally, the data shows that nonconfirmation rates obtained by Medicare beneficiaries are sufficiently high to generate a sentinel effect within the physician community if a mandatory SSOP is established.

The Abt Associates, Inc. study confirmed "that proposals of surgery on older patients are less likely to be confirmed than those on younger patients" and offered a clue as to why. While acknowledging that nonconfirmation rates resulting from the New York demonstration project were high, Abt reported that they were actually less than predicted (for the seven procedures mentioned above, 27.8 percent actual versus 31.7 percent predicted) by a panel of physicians which considered such factors as:

...the extent of pain expected during treatment and the expected length of recovery time;

...expected rates of morbidity and mortality following surgical and alternative treatments;

...the extent to which surgical and alternative treatment are expected to lead to cured, improved, unchanged or deteriorated status; and

...the extent to which pain, psychological distress, and mobility limitations are expected to follow surgical and alternative treatments.

The fact that the rates were predicted at such high levels indicates that risks associated with surgery on the elderly were given much consideration by the physician panel. It also indicates that mandatory SSOPs for Medicare may be even more successful in reducing elective surgeries than Medicaid SSOPs where recipients, because of their younger age, face fewer risks associated with surgery.

PROs Do Not Eliminate Need For Mandatory SSOPs For Medicare Beneficiaries

In our audit of mandatory SSOPs, we did not review the effectiveness of PROs as an alternate method of reducing unnecessary surgeries because PROs did not begin operating until this fiscal year. Nevertheless, based on what we learned during our audit and subsequent readings of HCFA's agreements with the PROs, we do not share HCFA's opinion that PROs eliminate the need for mandatory SSOPs for the Medicare program. PROs do very little towards achieving one objective of SSOPs -- health consumer education -- and their effectiveness in reducing unnecessary surgeries is unknown.

One objective of SSOPs is to influence health consumers' behavior by encouraging them to be more informed and involved in decisions on their health care. The more information consumers have the better off they are in terms of making intelligent decisions with more confidence and peace of mind about those decisions.

Mandatory SSOPs accomplish this consumer education objective very well. By requiring a second opinion from another physician as a precondition for coverage of certain surgical procedures, mandatory SSOPs overcome the natural tendency of patients, particularly the elderly, to avoid the appearance of offending their physicians by voluntarily seeking second opinions. Patients have a built-in excuse to visit another physician to obtain a second independent opinion on the need for proposed surgery. According to the Committee testimony provided by the representative from the American Association of Retired Persons, the consumer education role is one of the most attractive features of mandatory SSOPs and one which would be of immense help to Medicare beneficiaries.

PROs do not even attempt, for the most part, to educate health consumers. Their activities are primarily limited to a review of documentation prepared by physicians who recommended the surgery. Minimal patient contact is anticipated.

HCFA believes that PROs can be as successful as mandatory SSOPs in reducing unnecessary surgeries. Its belief is based on the premise that PROs will generate the same sentinel effect as mandatory SSOPs. As we previously pointed out, it is the sentinel effect that is credited with most of the reductions in surgery attributed to mandatory SSOPs.

It remains to be seen whether a PRO documentation review will generate the same sentinel effect as a mandatory SSOP patient examination. We noted, however, that one PRO has serious misgivings. This PRO questioned the traditional PRO methodology for reducing unnecessary surgeries. According to the PRO, when a physician records on the chart that a patient is incapacitated or suffering from pain, there is no way of disputing this claim either at the time of admission to a hospital, or even more so after discharge. The PRO stated that such statements in medical records constitute nothing more than the subjective opinion of the physician that should be subject to the scrutiny provided by mandatory SSOPs.

The PRO concluded that a mandatory SSOP in one state could, in a period of two years, eliminate 625 unnecessary surgeries, 4 unnecessary deaths and 37 unnecessary complications resulting from the unnecessary surgeries. In addition, the PRO estimated that it would cost about 50 percent less to operate a mandatory SSOP than to continue traditional PRO reviews. The net result in terms of costs -- savings of $6 million and a cost benefit ratio of 1 to 8.83.

If the PRO is correct in claiming that some physician statements cannot be easily substantiated, the size of the sentinel effect generated by PRO reviews could be seriously affected. Physicians may not fear peer review if they know the documentation they submit to support a surgery decision cannot be validated.

We have other concerns, however, about the effectiveness of PRO reviews in generating sentinel effects. PROs have eight separate objectives, most of which deal with the appropriateness of admissions to hospitals versus use of ambulatory surgical centers or other outpatient facilities. Only one or possibly two (depending on which PRO is contacted) of the eight objectives deal with reducing unnecessary surgeries and these objectives are restricted to only those selected surgeries that are to be performed in hospital settings. Since more and more surgeries are being performed outside the hospital, PROs automatically exclude a sizeable portion of surgeries from their reviews.

More important than this exclusion, however, is the fact that PROs severely limit the number of surgical procedures that are reviewed for necessity. These restrictions are so significant that, in my opinion, the overall impact of the sentinel effect of PRO hospital pre-admission reviews on eliminating unnecessary surgeries is greatly diluted.

For example, our review of HCFA's agreements with 51 PROs show that 29 of them gave no indication in Quality Objective Area IV (the one objective indisputably aimed at unnecessary surgeries) that they planned to review the medical necessity of any of the common surgical procedures which we included in our proposed mandatory SSOP. As illustrated by the following chart, PRO review coverage was such that large segments of the Medicare population may not have been afforded any systematic protection against unnecessary surgeries.

Surgery	Number of PROs Not Reviewing Procedure	Percent of Medicare Population Not Covered
Prostate	38	79%
Joint Replacement	42	85%
Hernia	41	77%
Cataract	43	94%
Cholecystectomy	39	79%
Hysterectomy	41	89%
Hemorrhoidectomy	50	97%

HCFA believes that another (Admission Objective II) of the eight objectives is targeted at reducing unnecessary surgeries. Including this in the computation, we found that most PROs still do not review many procedures and that, in every instance, the majority of the Medicare population remains unprotected from unnecessary surgeries.

Surgery	Number of PROs Not Reviewing Procedure	Percent of Medicare Population Not Covered
Prostate	28	60%
Joint Replacement	39	80%
Hernia	37	68%
Cataract	33	80%
Cholecystectomy	34	67%
Hysterectomy	38	81%
Hemorrhoidectomy	45	90%

The above data shows a slight improvement in PRO coverage but there is some doubt as to whether Admission Objective II deals with unnecessary surgery. Contact with representatives of 12 PROs disclosed no consensus of opinion. Some PROs believe that the surgery itself is not contested but only the setting and others were not really sure at all about its purpose citing a lack of data.

Another potential weakness in PRO review is that many of them are retrospective in nature; that is, the reviews do not take place until after the surgery has been performed. Retrospective reviews may not adversely affect the generation of a sentinel effect but they are no help whatsoever to the Medicare beneficiaries who were operated on by the time of review.

Finally, the above charts assume that each PRO reviews 100 percent of the surgical procedures included in their agreements with HCFA. In only this manner could an individual PRO generate a sentinel effect for a particular procedure in their particular geographical area. There are some indications, however, that 100 percent reviews are not taking place. For example, HCFA requires PROs to review permanent cardiac pacemaker implantation procedure to determine necessity. My staff has reviewed documentation gathered from HCFA that shows that, if PROs continue their current rate of review, about 38,000 pacemaker implants will be reviewed in the next 12 months. According to the latest statistics from the National Center for Health Statistics, at least 106,000 implants can be expected over a 12 month period -- and this assumes no growth in the number of implants performed yearly. Therefore, less than 100 percent reviews will be conducted, further weakening the sentinel effect.

Conclusion

Mandatory SSOPs are effective in reducing unnecessary surgeries in Medicaid. Numerous studies including some financed by HCFA offer overwhelming evidence to that effect. The same studies conclude that the sentinel effect generated by mandatory SSOPs are responsible for the majority of their success.

We believe that mandatory SSOPs for Medicare can also be effective. The elderly are operated on more frequently than the general population and decisions to operate on them are nonconfirmed at least as often or more. These factors should result in a significant sentinel effect which will result in significant reductions in surgeries and costs.

PROs, too, have a place in the network of controls aimed at preventing Medicare abuses. The OIG supports HCFAs efforts in this area but we do not believe that PROs eliminate the need for mandatory SSOPs in Medicare. PROs were not designed to provide consumer education to the elderly and their ability to create a major sentinel effect similar to mandatory SSOPs is questionable based on their review coverage and methodology.

Based on an OIG review of the facts and issues, we conclude that mandatory SSOPs have been proven successful in reducing unnecessary surgeries in Medicaid, can be as successful in Medicare, and cannot be replaced by PROs. Accordingly, we support legislation requiring mandatory SSOPs for Medicare and Medicaid.

CONGRESSIONAL BUDGET OFFICE
U.S. CONGRESS
WASHINGTON, D.C. 20515

Rudolph G. Penner
Director

July 1, 1985

Honorable John Heinz
Chairman
Special Committee on Aging
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

In response to your letter of March 28, 1985, the Congressional Budget Office has estimated the budgetary impact of mandating a second surgical opinion program in Medicaid and in Medicare. We estimate that in 1986 a mandatory second surgical opinion program (SSOP) would save the federal government about $20 million in Medicaid and $80 million in Medicare.

The estimated savings in Medicare, however, are very uncertain. Because no study has been done of the reductions in surgery rates in Medicare (or among the aged population) as a result of a mandatory SSOP, the SSOP's effects are largely speculative. It is possible that the costs of a SSOP could exceed any savings or that savings could be even higher than our estimates.

To estimate the effects of a mandatory SSOP in Medicare, we assumed that estimated reductions in surgery rates from a SSOP in Medicaid could be applied to Medicare. The surgical procedures, however, would be likely to be different between the aged and non-aged populations, and--perhaps most importantly--the effects on the two populations might also be very different. Yet another uncertainty is the extent of any overlaps between a mandatory SSOP and the Medicare Peer Review Organizations (PROs). To the extent that the PROs require hospital preadmission reviews and targeted post-surgery reviews, the SSOPs might have little, or no, additional effect on surgery rates. Because the PROs have just begun to implement their programs, we do not yet have a firm idea of their effects.

The remainder of this letter explains the CBO methodology.

Medicaid

The savings of $20 million were based on a study of a mandatory SSOP in the Medicaid program in Massachusetts. This study by Abt Associates Inc., entitled Second Surgical Opinion Programs: Public Policy Alternatives (Preliminary Draft, December 1984), found net savings of around $1 million a year in 1977-1978 from the SSOP in Massachusetts. We calculated the percentage reduction in Massachusetts Medicaid expenditures due to these SSOP net savings, and assumed that other states would have identical percentage reductions in their expenditures. Finally, we eliminated savings for those states that already have mandatory SSOPs in Medicaid (Massachusetts, Michigan, Minnesota, Missouri, New Jersey, Wisconsin, Washington, Tennessee, Oregon, and Virginia).

Other estimates besides that of Abt have been made of the effects of SSOPs, some by the states and some by private insurers. The Abt study, however, is the most thorough, and the only one that controls for the many other factors causing surgery rates to change over time. For that reason, CBO based its estimates of the effects of SSOPs in both Medicaid and Medicare on the Abt study.

Medicare

In estimating Medicare savings, several steps were necessary to develop an estimate, including estimating reductions in surgery rates, savings from any reductions in surgeries, and costs of the SSOP program. Each is discussed below. The steps to reach final savings are also summarized in Table 1.

TABLE 1. ESTIMATED SAVINGS AND COSTS OF A MANDATORY SECOND SURGICAL OPINION PROGRAM IN MEDICARE (Fiscal year 1986, in millions of dollars)

	Costs			
Savings from Reduced Surgeries	Alternative Treatments	Consultation Fees	Administration of SSOP	Net Savings
-300	30	95	95	-80

Reductions in surgery rates. The Abt study found a 7.5 percent reduction in the surgery rate statewide for seven surgical procedures (hemorrhoidectomy, cholecystectomy, hysterectomy, laminectomy/disc excision, meniscectomy, submucous resection, and excision/ligation of varicose veins). This reduction is lower than what Abt found for the

Massachusetts Medicaid SSOP, which also included tonsillectomies for which a large decline in surgery rates was found. Because tonsillectomies are not relevant for the aged population, we excluded their effect on surgery rates.

We then assumed that this same reduction of 7.5 percent in surgery rates would apply to ten Medicare procedures: cardiac pacemaker, coronary bypass, cataract, gall bladder, prostate, knee, hysterectomy, back, hernia, and hemorrhoidectomy. The reduction in the number of surgeries for each procedure for persons aged 65 or over was then calculated using surgeries as reported in the National Hospital Discharge Survey for 1983.

Savings from reduced surgeries. The savings associated with each reduced surgery were estimated for each surgical procedure. Savings include DRG reimbursements to hospitals, increased to cover medical education and capital cost payments to hospitals and reduced to allow for the deductible in Medicare Hospital Insurance. They also include payments under Medicare Supplementary Medical Insurance for surgeons' fees, anesthesiologists, and related costs, less coinsurance and deductibles. These estimated savings from reduced surgeries (before adjusting for PROs) totaled $485 million in fiscal year 1986. Under current law, however, some of these savings from reduced surgery rates should result from the recent PRO initiative. The PRO program was mandated in the Tax Equity and Fiscal Responsibility Act of 1982. The PROs started functioning during the second half of 1984.

The PROs hope to reduce the number of inappropriate or unnecessary admissions or surgeries. This objective is to be met most often by preadmission reviews and post-surgery reviews. Such reviews, when they cover most of a state's surgeries or are targeted on specific hospitals or doctors, should lower surgery rates in the same manner as would SSOPs. As a result, savings from SSOPs would be reduced or eliminated for some procedures in some states. Based on a review of PRO objectives for each state, and on estimates of PROs progress in meeting their objectives, CBO has estimated an offset for PROs, that is, the proportion of the net savings from SSOPs that would be eliminated because of the PROs. The offset is estimated to be about $185 million in 1986, or about 38 percent of SSOP's savings from reduced surgeries. We therefore estimate the savings from current law of reduced surgeries to be $300 million ($485 million minus the PRO adjustment of $185 million).

The PRO adjustment as estimated by CBO was based on a review of each state's objectives, particularly admission objective II and quality objective IV. Because the pre- and post-admission reviews usually involved reviews of either all surgeries for specific procedures or were targeted, we assumed that they would offset in full any SSOP savings for that procedure in that state. Where PROs appear to be falling short of meeting their objectives, however, the offset was reduced.

Forgoing a surgery may result in costs for alternative treatments. These alternative costs were estimated to be 10.3 percent of the savings from reduced surgeries, based on a study by Suzanne Martin et al, entitled The Effect of a Mandatory Second Opinion Program on Medicaid Surgery Rates--An Analysis of the Massachusetts Consultation Program for Elective Surgery (September 1980). We estimated these costs as SSOP savings from reduced surgeries after PRO offsets times 10.3 percent.

Costs of the SSOP program. Running a SSOP program--paying for second opinion consultations, tracking surgeries that require second opinions, certifying doctors to give second opinion consultations, making referrals to these doctors and possibly arranging appointments, and checking to make sure that second opinions are obtained before hospital and doctor costs are reimbursed--could be costly. These costs as estimated by CBO total $190 million in 1986.

The first component of these costs--consultations--is estimated to be $95 million in 1986. Second opinion consultations are free of charge to the Medicare beneficiary. The CBO estimate was based on an average consulting fee of $80 in 1986, which was in turn based on Medicare consulting fees consistent with the Massachusetts SSOP fee categories of "limited consultation", "extended consultation", and "consultation of unusual complexity". The proportions of consultations in each fee category were based on the Massachusetts SSOP proportions. Consulting costs were then calculated as the number of surgical procedures, less waivers for emergencies or for travel hardship (estimated at 13 percent of surgeries based on the Abt study), times $80.

The second component of these costs--administration of the SSOP program--is estimated to be $95 million in 1986. The CBO estimate was based on an estimated cost of $70 per surgery, using the Abt study and a second study (Eugene G. McCarthy et al, Study on Mandatory Second Opinion for Elective Surgery, November 1984) and adjusting costs to 1986 by increases in the CPI.

After adjusting for the costs of a SSOP program, the net savings from a mandatory SSOP in Medicare are estimated to be $80 million in 1986.

Your staff on the Committee on Aging, particularly David Schulke, has been especially helpful to us as we worked on this estimate. Not only did they provide us with dozens of studies but they also spent considerable time contacting PROs. We are very appreciative.

If you have any questions, please call me or have your staff contact Janice Peskin or Anne Manley (226-2820).

With best wishes,

Sincerely,

Rudy Penner

Rudolph G. Penner
Director

cc: Honorable John Glenn
Ranking Minority Member

July 12, 1985

MEMORANDUM

TO: David Schulke (Special Committee on Aging, U.S. Senate)

FROM: Anne Manley AM (Congressional Budget Office)
Jack Rodgers

SUBJECT: Five-Year Savings from a Mandatory Second Surgical Opinion Program (SSOP) for Medicare and Medicaid

The Congressional Budget Office recently completed an estimate for the savings from a Mandatory Second Surgical Opinion Program (SSOP) for Medicare and Medicaid, as proposed by Senator Heinz. We estimated savings of $80 million in Medicare and $20 million in Medicaid for a fully implemented program in fiscal year 1986. Adjusting for a phase-in period during fiscal year 1986 and medical inflation thereafter, savings would be:

(by fiscal year, in millions of dollars)

	1986	1987	1988	1989	1990
Medicare	-40	-85	-90	-100	-110
Medicaid	0	-20	-25	-25	-25

The 1986 savings in Medicare are half those discussed in the letter of July 1, 1985, because the proposed legislation provides for a six-month phase-in period after enactment. The savings in Medicaid are insignificant during the first year after enactment because states that must legislate a mandatory second opinion program are allowed until the close of their first legislative session after October 1, 1985 to implement a SSOP. We have assumed that all states provide in regulation or legislation for a six-month phase-in period.

APPENDIX 4

BUSINESS AND HEALTH

Second Opinion: A Tool to Save Money, Improve Care

BY RICHARD J. HANLEY AND JACQUELYN T. AYERS

Owens-Illinois uses nurse coordinators to help employees field surgery questions.

COST MANAGEMENT REPORT

A mandatory second opinion program introduced at Owens-Illinois, Inc. in 1983 achieved significant cost savings — $300,000 — in the first year, while preserving each patient's freedom of choice and increasing employee awareness of health care alternatives. These savings represent a return of more than $4 for each $1 it cost to operate the program.

Initially, the program, which was designed and administered by Parkside Health Management Corporation, covered about 8,000 salaried employees and their dependents. As a result of subsequent union negotiations, it was extended last year to cover most of the company's hourly employees and dependents as a way to get them more involved in the efficient use of the health care system. Owens-Illinois has a total domestic employment of about 30,000 persons.

Employees are required to obtain a second opinion for 13 nonemergency procedures where surgery is frequently recommended when other forms of treatment may also be applied. These 13 surgical procedures are back surgery, breast surgery, bunionectomy, cataract removal, dilation and curettage, gallbladder removal, hernia repair, hysterectomy, knee surgery, nose surgery, prostatectomy, tonsillectomy and adenoidectomy, and varicose vein surgery.

Employees' Choice

Although seeking such an opinion is mandatory — unless an employee wants to pay a penalty equal to 20 percent of the expenses associated with the surgery — the Owens-Illinois plan preserves freedom of choice. A confirming second opinion is not required to approve full benefit coverage for the surgery. The final choice of whether to have surgery is up to each patient.

It is widely believed that patients seldom act against the advice of their own doctors. Yet the experience of Owens-Illinois is that patients, in fact, generally go against their doctors' recommendations when they receive a nonconfirming second opinion.

In 1983, for example, 435 second opinions were obtained under the mandatory program; an additional 24 voluntary second opinions were obtained, for a total of 459. In 19 percent of these cases, the second opinion was nonconfirming. Fully 88 percent of those patients receiving a nonconfirming second opinion chose a plan of nonsurgical treatment instead of proceeding with surgery, as had been recommended by their original doctors (see Tables I and II).

In 22 additional cases, surgery was avoided after two confirming opinions, when patients decided to pursue nonsurgical treatments anyway. In all, surgery was avoided in 97, or 21 percent, of the 459 second opinion cases in 1983.

Second opinion program data for the first six months of 1984 show a decline in the number of nonconfirming opinions, as often happens during the second year of a program. Of 193 mandatory second opinions obtained, only 19, or 10 percent, were nonconfirming. That compares with 19 percent for 1983. This decline may be an indication of the "sentinel effect" — the idea that physicians may not recommend surgery in marginal cases if they know that a second opinion will be obtained.

The percentage of avoided surgeries after nonconfirming opinions remained high during the first six months of 1984. Patients in 18 of the 19 cases involving nonconfirming opinions decided not to have surgery. This means that 95 percent of the patients in this group avoided surgery, as compared with 88 percent for all of 1983.

These results document the effectiveness of a man-

Richard J. Hanley is vice president of health care policy and programs at Owens-Illigois, Inc. in Toledo, Ohio, and Jacquelyn T. Ayers is director of professional services at Parkside Health Management Corporation in Toledo.

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dates second opinion program, once a relationship of trust with patients is established. This trust is built and maintained by teams of Parkside registered nurses with special training and experience in patient counseling and surgical nursing. These nurses, called patient services coordinators, provide professional counseling on the second opinion process and on cost-effective health care alternatives. They are available to Owens-Illinois employees on toll-free telephone lines. The service is completely confidential, and nothing in the patient's personal medical history is transmitted to the company without the individual's consent.

TABLE I

Nonconfirming Second Opinions 1983

	Mandatory	Voluntary	Total
Second opinions	435	24	459
Nonconfirming opinions	76 (17%)	9 (36%)	85 (19%)
Surgeries avoided following nonconfirming opinions	66 (87%)	9 (100%)	75 (88%)

This is how the system works. When surgery is recommended, the patient services coordinator provides the patient with a list of three physician consultants qualified to offer second opinions on the proposed surgery. The final choice of the physician consultant is made by the patient.

More than 3,000 physicians now serve on Parkside second opinion panels nationwide. They are carefully selected because of their training, experience and reputation for providing quality care. Panel members must be board certified or board eligible in their specialty, and must agree not to perform the surgery on the second opinion patient. The panels include 13 categories of medical specialists: internists, surgeons, pediatricians, oncologists, cardiologists, gastroenterologists, gynecologists, neurologists, opthalmologists, otolaryngologists, orthopedists, allergists and urologists.

Patient services coordinators have authority to act in a clinical capacity to grant waivers of second opinions due to timing, lack of a qualified second opinion physician in the patient's location and other appropriate variables. Coordinators are also available to answer questions to help clarify the surgery decision facing the patient and to provide counseling on a wide range of health care subjects. This counsel may include considerations such as inpatient vs. outpatient surgery, selection of a physician, preadmission testing, weekend hospital admissions, home health care opportunities and rehabilitation programs that can help people return to work at an earlier date.

Gains for the Employer, Employee

Cost savings from surgeries avoided totaled more than $180,000. In addition, many patients who decided to proceed with surgery were able to achieve significant savings in the care they received with the help of patient services coordinators who counseled them about having tests done before being admitted to the hospital, recovering at home and other cost saving approaches. Owens-Illinois has not broken-out separately the cost savings from reduced lengths of hospital stay for the second opinion program alone. However, lumping together second opinion and other employee case management, education and counseling programs, the company estimates that a reduction in hospital stay for salaried employees was 655 days in 1983. Savings from these reduced days in the hospital are estimated at more than $260,000, at least half of which were achieved by patients whose initial contact with coordinators came through the second opinion program. Thus, it is calculated that total savings generated by second opinion case management services exceeded $300,000.

Avoided surgeries and shortened hospital stays also increased the productivity of Owens-Illinois' work force by sharply reducing the number of workdays lost to health care problems. The company estimates these productivity gains to be nearly $90,000. While these are indirect savings, they have the same impact on corporate finances.

Beyond these impressive gains in cost containment, additional benefits of the second opinion program can be illustrated by reviewing the details of some individual cases.

- A proposed hernia surgery proved unnecessary when a second opinion consultant discovered the real cause of the problem: two nonabsorbable sutures from a previous operation.

- A patient avoided a dilation and curettage operation when the second opinion physician determined that the problem could be corrected by removal of a polyp which could be performed in an office setting.

- A second opinion consultant advised a patient that proposed bunion surgery probably would not correct the symptoms and recommended using arch supports instead. The patient decided to defer surgery.

- An employee accepted the advice of a second opinion consultant who agreed with the need for knee surgery but recommended a less extensive operation.

The examples given above and many others at Owens-Illinois provide encouraging evidence that patients given adequate information, incentives and assistance are both willing and able to be cost-effective health care consumers. Patient involvement in the health care process is the key to success.

According to an evaluation survey completed by nearly half of the employees using this service, response of patients who have sought a second opinion has been overwhelmingly favorable. As one patient put it: "The second opinion doctor reinforced my doctor's advice and made me more comfortable with my decision." Another patient commented: "I felt much more secure about the diagnosis and treatment following the second opinion. Also, [the nurse coordinator] was informative, friendly and supportive. Since I am single and most of my family is out of state, this kind of support was much appreciated."

As may be expected, however, not every participant responded favorably to the concept of second opinion, and a few expressed dissatisfaction with the second opinion consultant. For example, one patient wrote: "Second opinion was of no benefit to me whatsoever." Another said: "The second opinion physician was brusque, rude and uncaring."

Evidence that such complaints represent minority points of view came from a review of overall survey results. Participants rated several aspects of the program on a scale of one to seven, from excellent to poor. Here is a summary of their responses.

	Excellent	2	3	4	5	6	Poor
I was able to make a more informed decision regarding treatment as a result of the second opinion consultation.	30%	30%	11%	12%	2%	5%	10%
The second opinion consultant was informative and supportive.	38	39	9	7	1	2	4
The consultant did a good job of explaining my condition and the options available to me.	38	38	9	8	2	2	3
The patient services coordinator was courteous and helpful.	67	21	8	3	1	0	0
Literature sent by the coordinator was helpful and informative.	46	37	4	8	4	0	1

Lessons Learned

Because of the effective role patient services coordinators have played in the second opinion program, Owens-Illinois decided to extend their responsibilities to include a broader range of cases involving potential hospitalization. Inpatient care accounts for about 60 percent of health care costs for the company, but second opinion surgery accounts for only about 20 percent of those hospital cases.

To enable the nurse coordinators to become involved in the other 80 percent, new health care plans for salaried employees and retirees require patients to notify the patient services office prior to all nonemergency hospital admissions. In emergency cases, notification is to take place within three days. These changes became effective this January.

As with the mandatory second opinion program, the penalty for noncompliance with the prenotification requirement is an 80 percent reimbursement instead of 100 percent coverage of reasonable and customary expenses. The requirement should enable patient services coordinators to serve a greater number of patients, particularly those with serious and recurring medical problems, thus yielding significant additional savings.

Owens-Illinois also stands to gain from an increasing percentage of surgery performed on an outpatient basis. Data for the first half of 1984 show that 73 surgeries out of 175 second opinion cases occurred in the outpatient setting. This represents 42 percent of all cases. These findings reflect a number of factors including: the involvement of the patient services coordinators; the increasing employee awareness of the outpatient alternative; changes in provider practices; and an Owens-Illinois requirement, effective in 1983, that certain surgical procedures be performed on an outpatient basis unless the physician recommends otherwise. Some of these outpatient procedures, such as bunionectomy and dilation and curettage, also require a second opinion.

No matter whether it is recommended on an inpatient or outpatient basis, the Owens-Illinois second opinion program clearly shows that unnecessary surgery can be avoided in a significant number of cases. This means reduced risk to the patient and may well mean a more effective form of treatment. And when surgery is necessary, the patient services coordinators can provide counseling to avoid unnecessary costs by encouraging outpatient surgery, or reducing length of hospital stays through preadmission testing and home health care or exploring opportunities for less extensive surgery.

TABLE II

Mandatory Second Opinion Procedures 1983

	Second Opinions	Nonconfirming Opinions	Surgery Avoided (after nonconfirming opinion)
Mandatory			
Back	29	11 (38%)	11 (100%)
Breast	23	9 (39%)	7 (78%)
Bunion	22	8 (36%)	6 (75%)
Cataract	52	3 (6%)	3 (100%)
Dilation and Curettage	43	3 (7%)	3 (100%)
Gall Bladder	25	3 (12%)	2 (67%)
Hernia	40	2 (5%)	2 (100%)
Hysterectomy	53	9 (17%)	8 (89%)
Knee	58	16 (28%)	13 (81%)
Nose	25	1 (4%)	1 (100%)
Prostate	17	3 (18%)	3 (100%)
Varicose Vein	6	3 (50%)	3 (100%)
Tonsillectomy and Adenoidectomy	41	5 (12%)	4 (80%)
Total	435	76 (17%)	66 (87%)
Voluntary	24	9 (38%)	9 (100%)
Total	459	85 (19%)	75 (88%)

As a result, the second opinion process gives patients a better understanding of their medical condition and of the expected results of the proposed surgery. Those who elect to have surgery do so with greater confidence that they have made the right decision. This can improve chances for a successful surgery and a speedy recovery — which can be the most important benefit of all. ■

APPENDIX 5

JOHN HEINZ, PENNSYLVANIA, CHAIRMAN
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United States Senate
SPECIAL COMMITTEE ON AGING
WASHINGTON, DC 20510

April 26, 1985

Thomas B. Graboys, M.D.
Director
Clinical Services
Cardiovascular Laboratories
Assistant Professor of Medicine
Harvard University Medical School
Boston, Massachusetts 02115

Dear Dr. Graboys:

As Chairman of the Special Committee on Aging, I am writing to thank you for your key role in the Committee's March 14 hearing, entitled "Unnecessary Surgery: Double Jeopardy for Older Americans". The testimony you provided, particularly your study of the efficacy of second opinions in reducing unnecessary coronary artery bypass graft surgery, was a vital and substantive contribution to the Committee's inquiry. The lively questioning and discussion provoked by your testimony is a good indication of the Members' strong interest in your research.

I would also like to take this opportunity to apologize to you for the protracted interval between the hearing and this formal expression of the Committee Members' appreciation for your efforts. This unfortunate delay occurred because Committee staff time was immediately and necessarily devoted to a detailed investigation of evidence of defective pacemakers and related unnecessary reimplantation surgery. Meanwhile, I am informed that staff are now processing documentation needed for reimbursement of your travel expenses, and will be forwarding these materials to you. Please accept my regrets for the undue delay and concern this situation may have caused you.

Your extensive background in the identification and control of patterns of utilization of cardiac pacemaker surgery provides a second reason for this letter. I have attached questions generated during the Committee's preparation for the March 14 hearing, some of which have become germane to the present investigation. As a preface to these questions, however, I would like to provide you with some background on the status of the Committee's ongoing inquiry into problems in Medicare-financed cardiac pacemaker surgery.

I authored amendments to the Deficit Reduction Act of 1984 which provided for the establishment of a National Pacemaker Registry, and mandated studies on Medicare reimbursement of physicians and hospitals for pacemaker surgery. The Prospective Payment Assessment Commission (ProPAC) completed its report on Part A reimbursement by the statutory deadline of March 1st. I have enclosed a copy of ProPAC's report for your review and comment. The Health Care

Financing Administration (HCFA), however, has missed its March 1st deadline for reporting on the adequacy and appropriateness of physician reimbursement, and now anticipates completing its review by August.

The National Pacemaker Registry, which was to be established by January 1, 1985, would contain data on all pacemaker implants and reimplants, as well as pacemaker warranty information. The Registry was designed to protect Medicare beneficiaries from defective pacemakers and unnecessary pacemaker reimplants, as well as providing Medicare with recoupment on warranties for failed pacemakers. Committee inquiry indicates, however, that establishment of the registry itself and promulgation of the regulations required for its operation and maintenance are experiencing lengthy delays.

In sum, this hearing will update the Committee's 1982 investigation by examining the progress made in recent years toward protecting beneficiaries from unnecessary, expensive, and hazardous pacemaker surgery. In addition, we will seek to determine if problems persist today, despite these advances.

In this context, I would very much appreciate your responding to the following questions on cardiac pacemaker utilization:

1. According to internal Medicare memoranda obtained by the Committee, the utilization and quality control Peer Review Organizations (PROs) have reviewed over 22,000 pacemaker surgeries -- mostly in retrospective reviews of surgeries already performed -- and have approved all but 333 of these (1.5%) as necessary and appropriate. Do these figures comport with your sense of the degree of inappropriate utilization of pacemakers?

2. I understand that you participated in an ad hoc panel of leading cardiologists, whose study of pacemaker utilization yielded a set of conservative guidelines or indications for pacemaker implantation, and was subsequently published in the Journal of the American Medical Association (JAMA) on September 14, 1984. I have enclosed for your review a copy of HCFA's guidelines for pacemaker surgery, as developed by the Public Health Service in 1983, and a copy of the New York State Peer Review Organization's pacemaker criteria, which were based upon the Medicare's guidelines. Are there any significant differences between the JAMA guidelines and Medicare's? What is your opinion of the efficacy of the Medicare guidelines, in light of recent progress toward an improved understanding of appropriate indications for this surgery?

3. Are you aware of any studies or evidence that pacemaker surgery is an overutilized procedure?

4. According to a new General Accounting Office report to be released at the hearing, dual chambered pacemakers now account for some 24% of all pacer implants, compared to only 5% in 1981. What are the implications of the increasing use of this sophisticated device, especially for the Medicare program?

5. In your view, is Medicare paying a prudent and reasonable price for the services of surgeons involved in implanting pacemakers?

Finally, I have one additional question for you, which I was unable to ask due to time constraints in the March 14th hearing. Your answer will be made a part of the record of this hearing which is now being prepared:

6. Your preliminary findings relating to the efficacy of second opinion as a means of reducing rates of coronary artery bypass graft surgery indicate that some 75% of those patients who took advantage of your prototype program were able to safely avoid this major surgery. If Congress required all of the approximately 63,000 Medicare patients who will have bypass surgery this year to first obtain a second opinion from doctors comparable to those on your team, what proportion of these patients do you think might safely avoid this surgery, with what savings to the program in physician and hospital payments?

If possible, I would like to receive your answers to these questions by May 8, 1985, so they may be available for study prior to the Committee's next hearing on this subject. On behalf of the Members of the Special Committee, I very much appreciate your taking the time and trouble to assist us in this way. Should you have questions regarding this letter, please contact David Schulke or James Michie of the Committee staff at (202) 224-5364.

Again, thank you for your continuing cooperation and assistance.

Sincerely,

John

JOHN HEINZ
Chairman

Enclosures
JH:dsm

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STEVEN LAMPERT, M.D.
CHARLES M. BLATT, M.D.

May 10, 1985

The Honorable John Heinz
Chairman
Special Committee on Aging
United States Senate
633 Dirksen Building
Washington, DC 20510

Dear Senator Heinz:

I apologize for the delay in responding to your letter of April 26th but, as I indicated to David Schulke, I had been out of the country and only now have had opportunity to reply. With regard to the specific questions posed:

1. The figure of 1.5% unnecessary pacemaker implantations, as judged by PRO utilization review, does not I believe reflect the actual number of inappropriate pacemaker implantations. Based on our group's experience with second opinions for pacemaker implants; our experience with explantation (removal) of pacing units in a number of patients and our working group's own recommendations as published in the Journal of the American Medical Association (JAMA), that figure of 1.5% is woefully low.

2. The Medicare guidelines for pacemaker implantation allow for a wide range of interpretation, particularly in the area of bradycardia (#s I5-7). There are elderly people who will exhibit heart rates in the 40's, feel perfectly well, yet experience some occasional dizziness unrelated to slow heart rate, and will be deemed candidates for pacemaker implantation. Group II categories are quite loose, particularly II-6. Again, many elderly people will be receiving medication for high blood pressure or angina pectoris which does slow the heart rate. There are physicians who will implant a pacemaker in anticipation of bradycardia which may or may not occur with those particular medications. Similarly, the New York STate Peer Review guidelines are questionably liberal; specifically conditions #5 & 7.

   Our guidelines in JAMA can be summarized in two major categories:

A) Symptomatic advanced or complete AV block.
B) Symptomatic bradyarrhythmia not induced by drugs or concomitant metabolic abnormalities.

3. I am not aware of "hard data" which addresses overutilization of pacemakers other than the collective experience of individuals such as those in our working group organized by Brendan Phibbs.

4. There is categorically no scientific reason why the percent of dual-chambered pacemakers has risen from 5% to 24%. Only a small minority of patients require dual-chamber pacing. Furthermore, the complexities of those pacemakers with the attendant pacemaker-induced arrhythmias has created problems in management of patients only rarely encountered previously with single-chamber pacemakers.

My own bias is that if reimbursement were precisely the same for single and dual-chambered pacemakers, the implantation rate of these units would drop dramatically. Industry does an impressive "marketing job" on physicians, urging their use of these units (see enclosure).

The implications of the increasing use of these units will be further cost not only in terms of the surgical and cardiologic fee, but also in followup because of the so-called "pacemaker-mediated tachycardias."

5. As I understand from Mr. Schulke, reimbursement for the surgical fee is somewhere between $1,000-2,000 dollars for this procedure. Considering the fact that if I spend one hour examining and counseling a heart attack patient in our office for which Medicare may reimburse me $50-60, the fee paid for a one-hour relatively simple procedure is unconscionable.

6. The data presented on second opinions for coronary bypass surgery should be framed in the context of those patients with chronic stable symptoms, and not those individuals admitted to hospital with unstable angina, requriing urgent surgery. If we assume that 1/3 of the 60,000 Medicare patients fall into the "unstable" group and the remaining 40,000 are "stable" and thus suitable for mandatory second opinion, a conservative estimate of those individuals suitable for deferred or avoided operation would be 50%. This translates to a savings of approximately 500 million dollars. If we subtract the cost of our medical second opinion program (see Appendix I), the savings are still in the range of 430 million dollars.

I do hope this information is of help to you and the Committee. It was an honor to have provided testimony and I will be available to assist in any way you deem necessary.

Sincerely,

TB Graboys, MD.

Thomas B. Graboys, M.D.
Director, Clinical Services
Cardiovascular Laboratories;
Assistant Professor of Medicine,
Harvard Medical School

/cmk:1-3

enclosure

→ cc: David Schulke

APPENDIX I

Projected cost of Second Opinion Center

$1500 evaluation fees (three visits at 6 month intervals over first 18 months). This fee incorporates all testing.

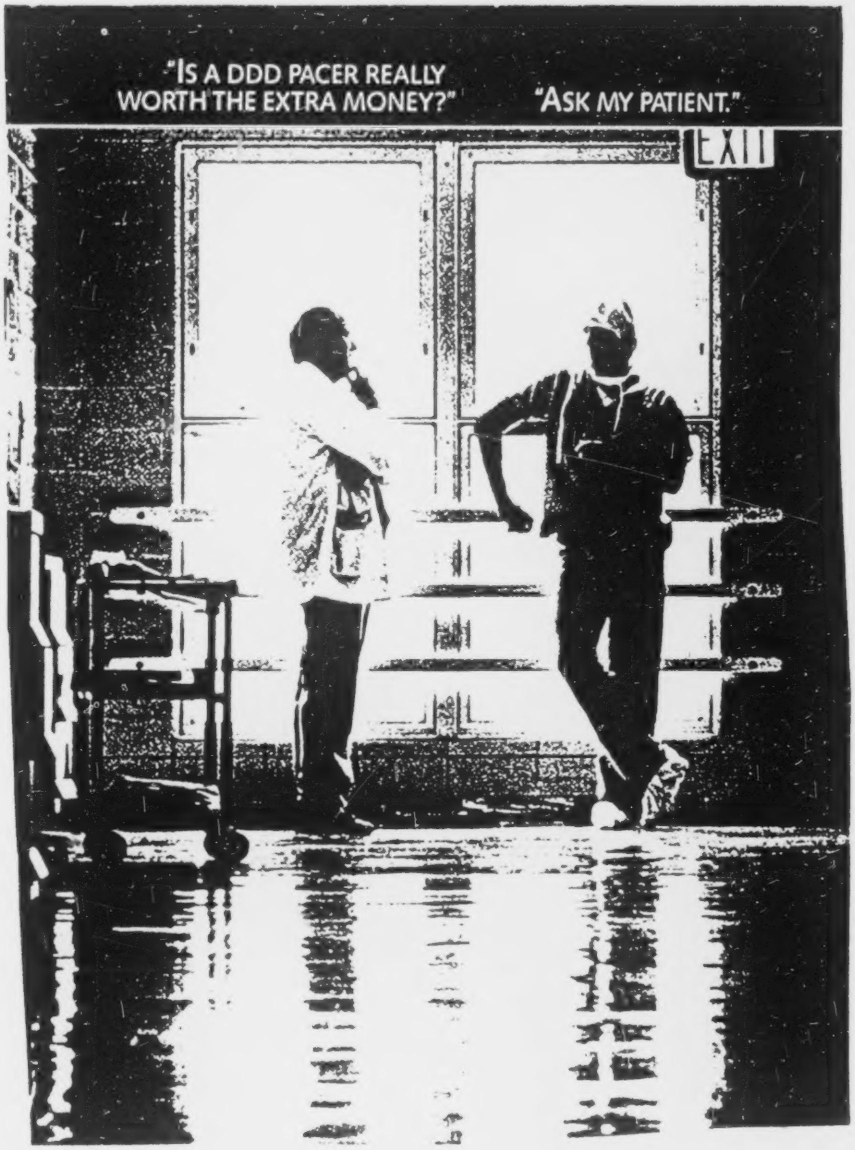
1500 x 40,000 = $60 million

plus one hospitalization at conservative cost of $5000 for 10% of the medically followed patients over a two-year follow-up - 10% x 20,000 patients = 2000 x $5000 = $10 million

Conservative Cost of Second Opinion Program = 70 million dollars

Net Savings = 430 million dollars

Pacemaker Co.
Advert.
1985


"IS A DDD PACER REALLY WORTH THE EXTRA MONEY?"
"ASK MY PATIENT."
EXIT

Abstract Form

Medical Research
Nursing Research

American Heart Association

Number ____________
Please do not fill in!

THE AMERICAN
HEART ASSOCIATION'S
58th
SCIENTIFIC
SESSIONS

November 11-14, 1985
Washington Convention Center
Washington, D.C

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Deadline Date: Abstracts must be postmarked no later than Monday, May 13, 1985.

Abstract of paper to be considered for presentation at the 58th Scientific Sessions, November 11-14, 1985, Washington, D.C.

For review and grading, assign this abstract to the Grading Category List number listed below:

Choice 1	**Choice 2**
Number 35	**Number** 36

Identify two key words or phrases to be used for indexing in the supplement to *Circulation*, an AHA journal:

1. ____________
2. ____________

☐

SECOND OPINION OPTION AMONG PATIENTS ADVISED TO UNDERGO CORONARY ARTERY BYPASS GRAFT SURGERY (CABG): RESULTS AND IMPLICATIONS

T.B. Graboys, S. Lampert, A. Headley, B. Lown, P.J. Podrid, Cardiovascular Laboratories, Harvard School of Public Health and Brigham & Women's Hospital, Boston, MA

A second opinion was sought by 91 patients (PTs) (79 males, average age 60 years, range 41-80) referred following recommendation for CABG because of angina pectoris and/or a previous myocardial infarction in 79% of PTs and "silent" ST segment changes during exercise testing in 11%. Coronary angiography revealed 28 (31%) with three, 38 (42%) with two and 25 (27%) with single vessel disease of >75% narrowing. Nine PTs (10%) had moderate or severe left main involvement while 82 PTs (90%) exhibited left anterior descending disease including all PTs with single vessel disease. Average ejection fraction for the group was 0.6. We recommended CABG in 14 PTs and continued medical therapy (MRx) in 77. After an average follow-up of 19 months (6-38), 70 PTs continue on MRx and 7 required CABG. There was one cardiac death in each group while 6 PTs in the MRx group had one additional cardiac related hospitalization for acute myocardial infarction.

Thus 75% of PTs initially recommended for CABG were safely followed on a MRx. The economic savings for this selected population approaches 1.5 million dollars.

The author affirms that the material herein will not have been previously published as a manuscript or presented at any national meeting, that any animal studies conform with the "Position of the American Heart Association on Research Animal Use" (see enclosed statement) and that any human experimentation has been conducted according to a protocol approved by the institutional committee on ethics of human investigation or — if no such committee exists — that it conforms with the principles of the Declaration of Helsinki of the World Medical Association (*Clinical Research* 14:193, 1966).

Author's signature ____________

The undersigned certifies that all authors named in this abstract have agreed to its submission for presentation at the AHA Scientific Sessions, and are familiar with the ten-author rule (see "Rules for Submitting Abstracts").